

32-000 CHILDREN'S MENTAL HEALTH AND SUBSTANCE USE TREATMENT SERVICES

32-001 General Requirements

32-001.01 Eligibility: An individual is eligible for mental health and/or substance use treatment services set forth in this chapter when:

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

32-001.02 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 shall:

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

32-001.03 Family Component: Unless otherwise prohibited, providers shall involve the family in assessment, treatment planning, updating of the treatment plan, therapy and transition/discharge planning. Providers shall schedule meetings and sessions in a flexible manner to accommodate a family's schedule, including weekends and/or evenings. Family involvement, or lack thereof, shall be documented in the clinical record. Parental/caregiver involvement in treatment is essential and evidence based practices which include parents in therapy are the expectation for treatment.

32-001.04 Cultural Competence: Providers shall be culturally competent. This includes awareness, acceptance and respect of differences and continuing self-assessment regarding culture.

32-001.05 Initial Diagnostic Interview: The Initial Diagnostic Interview shall include a history, mental status, and a disposition and may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies. If circumstances require, individuals such as family members, guardians or other supports may be interviewed to supplement the interview of the individual.

32-001.06 Practitioners Requiring Supervision: A Practitioner who is not eligible to practice independently and who provides mental health and/or substance use treatment services shall have a Supervising Practitioner:

1. Licensed Mental Health Practitioner
2. Provisionally Licensed Mental Health Practitioner
3. Registered Nurse (RN)
4. Provisionally Licensed Psychologist
5. Licensed Alcohol Drug Counselor (LADC)
6. Provisional LADC

32-001.06A A Supervising Practitioner shall be:

1. A licensed physician (M.D. or D.O.) who 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 (Ph.D. or 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.

32-001.06B Responsibilities of Supervising Practitioner: A Supervising Practitioner shall:

1. Develop, approve and supervise the client's assessment and treatment plan. This requires a face-to-face assessment;
2. Direct patient care by reviewing and approving client 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.

32-001.06C Reimbursement for Supervision: Face-to-face assessments and other services provided by the Supervising Practitioner, directly to the client, are reimbursable. Supervision is not reimbursable either by the Supervising Practitioner or the Practitioner who is being supervised.

32-001.07 Provider Enrollment: All providers of mental health and substance use treatment services shall submit a completed Medical Assistance Provider Agreement to Medicaid for approval. A separate application shall be submitted for each particular mental health and substance use treatment service.

32-001.07A Managed Care Enrollment: In order to be reimbursed for providing services to clients in managed care, providers shall be credentialed by and under contract with the Medicaid managed care behavioral health contractor.

32-001.08 Active Treatment: Treatment shall be provided in an interactive face-to-face environment with the client present and shall be focused on reducing or controlling the client's mental health and substance use disorder symptoms which cause functional impairments and promoting the client's movement to less restrictive treatment in the most time efficient manner consistent with sound clinical practice.

32-001.09 Treatment Plans: 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. The Treatment Plan shall include transition and discharge planning and shall be amended as needed as treatment progresses. The Treatment Plan shall:

1. Be individualized to the client;
2. Include the specific symptoms or skills to be addressed;
3. Provide clear and realistic goals;
4. Include treatment objectives services, strategies, and methods of intervention to be implemented;
5. Describe the methods for evaluating both the client's progress and the performance of the practitioner facilitating the intervention; and
6. Estimate the length of time or number of sessions necessary to complete the treatment goals.

32-001.10 Transition and Discharge Planning: Providers shall 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.

32-001.11 Coordination of Care: If the client receives services from more than one mental health and substance use provider, these providers shall coordinate their services.

32-001.12 Clinical Records: Each provider shall maintain a legible clinical record for each client that includes a complete record of all the treatment services rendered. The clinical record shall contain documentation sufficient to justify reimbursement and shall allow an individual not familiar with the client 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.

32-001.12A Progress Notes: Progress notes shall identify the client name, the name and title of the practitioner and the date of service. The progress note shall also identify the type of therapy, beginning and end date and time of the service delivered.

32-001.12B Record Retention: Clinical records shall be maintained for a minimum of seven years in a secure location.

32-001.12C Confidentiality of Records: Each provider shall ensure the confidentiality of clinical data, in accordance with state and federal law.

32-001.13 Location of Community Based Services: Community based mental health and substance use treatment services shall be provided in the client's home or a professional environment conducive to client confidentiality and privacy.

32-001.14 Quality Assurance, Utilization Review and Inspection of Care (IOC): Providers shall fully cooperate with any reviews conducted by Medicaid or Medicaid's designee to determine the quality of care and services provided. Providers shall have access to a copy of any final IOC report.

32-001.14A Response to IOC Reports: Within 15 days following the receipt of the IOC report, the provider shall 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.

32-001.15 Payment: Payment for services shall be based upon rates established by Medicaid, as described further throughout this chapter, and may be increased or decreased based on legislative appropriations or budget directives from the Nebraska Legislature. Providers may be required to report their costs on an annual basis or as needed.

32-001.16 Institutes for Mental Disease (IMD): Services provided to clients residing in an IMD shall not be Medicaid reimbursable except as provided in the regulations on PRTFs.

32-002 OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER TREATMENT SERVICES

32-002.01 Covered Outpatient Mental Health and Substance Use Disorder Treatment Services: Covered services include:

1. Crisis Outpatient;
2. Client Assistance Program (managed care benefit only);
3. The Initial Diagnostic Interview;
4. Psychological Testing;
5. Comprehensive Child and Adolescent Assessment (CCAA);
6. Comprehensive Child and Adolescent Assessment Addendum;
7. Individual Psychotherapy;
8. Group Psychotherapy;
9. Family Psychotherapy;
10. Parent Child Interaction Therapy (PCIT);
11. Child-Parent Psychotherapy (CPP);
12. Individual Substance Use Disorder Counseling;
13. Group Substance Use Disorder Counseling;
14. Family Substance Use Disorder Counseling;
15. Conferences;
16. Community Treatment Aide;
17. Medication Management; and
18. Sex Offender Risk Assessment.

32-002.02 Non-Covered Treatment Services: Services not covered include, but are not limited to:

1. Applied Behavioral Analysis (ABA);
2. Biofeedback Services;
3. Educational Services;
4. Behavior Modification and Planning;
5. Eye Movement Desensitization and Reprocessing (EMDR); and
6. Art, Play or Music Therapy.

32-002.03 Outpatient Services Providers: Outpatient services shall be provided by licensed practitioners whose scope of practice includes mental health and/or substance use disorder services.

32-002.04 Crisis Outpatient: Crisis outpatient individual or family therapy is an immediate, short-term treatment service provided to a client with urgent psychotherapy needs.

32-002.04A: The provider shall develop a short-term plan and shall identify ongoing treatment services if services appear to be medically necessary following stabilization. If services are to continue, the provider shall perform or arrange for an assessment and develop a treatment plan if one has not already been completed.

32-002.04B A client is eligible to receive crisis outpatient services of no more than five sessions per episode of crisis.

32-002.05 Client Assistance Program (CAP): The Client Assistance Program is a short-term, solution-focused set of interventions to assist a client in reducing or eliminating the current stressors that are interfering with the client's daily living and wellbeing. The client is eligible for up to five services per calendar year. If it is determined that the client needs additional treatment, the provider shall perform an Initial Diagnostic Interview and formulate a treatment plan if this has not already been completed.

32-002.06 Initial Diagnostic Interview: An Initial Diagnostic Interview as set forth in 471 NAC 32-001.04.

32-002.07 Psychological Testing: Psychological Testing is the administration and interpretation of standardized tests used to assess an individual's psychological or cognitive functioning. It assists in gaining an understanding of an individual's diagnostic presentation and informs the appropriate course of treatment.

32-002.07A Testing services shall 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.

32-002.07B Psychological Testing must be prior authorized. Before psychological testing, the individual 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 and/or helps resolve specific treatment planning questions. It may also occur later in treatment if the individual'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 Medicaid.

32-002.08 Comprehensive Child and Adolescent Assessment (CCAA): A CCAA is a comprehensive assessment of a juvenile's social, physical, psychological, and educational development and needs, including the recommendation for an individualized treatment plan when treatment is necessary and recommended.

32-002.08A A CCAA shall be covered for an individual under the age of 19 who is a Medicaid eligible ward of the State and who exhibits behaviors so severe that the individual has come to the attention of juvenile or county court.

32-002.08B A CCAA must be court-ordered. If the individual has received a CCAA in the previous 12 months and a subsequent evaluation is ordered, the provider shall obtain clinical information to complete an addendum to the current CCAA.

32-002.08C A CCAA shall be completed by a team of licensed and contracted practitioners led by a CCAA lead. The team shall include, at a minimum:

1. A psychiatrist;
2. A psychologist;
3. A physician to complete a wellness check; and
4. A Licensed Mental Health Practitioner (LMHP) or a Licensed Alcohol and Drug Counselor (LADC) or a Licensed Practitioner with expertise to conduct sex offender risk assessments.

32-002.08D Any CCAA provider conducting a substance use evaluation shall have completed the Comprehensive Adolescent Severity Inventory (CASI) training. All CCAA providers must be approved for the CCAA network by the State or its designee.

32-002.08E The CCAA lead shall complete a standardized report that coordinates all of the assessment information, makes a final recommendation for treatment and sequences the order of treatment if more than one recommendation is made. All treatment recommendations shall meet medical necessity criteria for the level of care recommendation. The Supervising Practitioner shall forward the report to the State or its designee who will forward the report to the court through the Office of Juvenile Services worker.

32-002.08F All components of the CCAA, including the standardized report with supporting documentation, shall be completed within ten working days of receipt of the request to complete the CCAA. The components are:

1. Records Search: A review and summary of the client's records including past evaluations, past psychiatric treatment records, information from current providers, school records, child welfare records, juvenile probation and juvenile diversion records and other relevant historical information.
2. Collateral Contacts: A review and summary of information obtained from collateral contacts relevant to the comprehensive assessment. At a minimum, it shall include the client's school, caseworker, care coordinator, probation/parole officer and past/present treatment providers.
3. Family Assessment: A current assessment addressing the family functioning, family dynamics and their impact on the client's treatment needs. The family assessment shall include all parents identified by the client's caseworker and shall be based on a direct face-to-face interview.
4. Comprehensive Adolescent Severity Inventory (CASI): Completion of all ten elements of the Comprehensive Adolescent Severity Inventory including:
  - a. Health information;
  - b. Stressful life events;
  - c. Education;
  - d. Alcohol and drug use;
  - e. Use of free time;
  - f. Peer relationships;
  - g. Sexual behavior;
  - h. Family/household members
  - i. Legal issues; and
  - j. Mental health.
5. Initial Diagnostic Interview: The Initial Diagnostic Interview includes a review of the first four components of the CCAA and the client's wellness check, an interview with the client, an evaluation of current medications or recommendation for medication and its management, a mental status exam and a diagnosis on all five axes of the most current DSM, if appropriate.

6. Wellness Check: A current wellness check includes but is not limited to the following:
- a. Client's height, weight, blood pressure, pulse, temperature, vision test results, hearing test results and medical history.
  - b. Any pertinent laboratory test completed by medical professionals.
  - c. Sexually transmitted disease testing (excluding HIV testing) when ordered by medical staff (if HIV testing is indicated, it should be noted in the recommendation).
7. Psychological Testing: Psychological testing and other mental health assessments if clinically applicable and appropriate. Additional testing/assessment shall be authorized separately from the CCAA but shall be incorporated into the CCAA and completed under the direction of the Supervising Practitioner. This may include, but is not limited to, psychological testing, sexual risk offender assessment, eating disorder assessment and substance use disorder assessments.

32-002.08G The standardized report shall contain and be signed by the CCAA lead:

1. Demographics;
2. A list of records reviewed and information sources contacted;
3. Presenting problem;
4. Medical history;
5. School/work/military history;
6. Alcohol/drug history and assessment summary;
7. Legal history;
8. Family/social/peer history;
9. Psychiatric/behavioral treatment history, including psychotropic medication;
10. Collateral information (family/friends/criminal justice/victim issues);
11. Case formulation/Clinical impression;
12. Psychological testing and specialty assessment results;
13. Substance use treatment recommendations, if applicable (include primary/ideal level of care recommendation, available level of care, barriers to ideal recommendations and client/family response to recommendations); and
14. Mental health treatment recommendations, if applicable.

32-002.08H The Supervising practitioner of the CCAA agency shall complete all necessary requests for authorization, treatment referrals and written applications, as required for services such as, but not limited to, PRTF, ThGH or PRFC. CCAA staff shall also participate in all peer and reconsideration reviews associated with these requests, as appropriate.

32-002.08I A community-based evaluation shall be completed in the client's home, the clinician's office or another setting in the community where the client normally resides. If this is not possible due to the distance between the client's residence and the CCAA provider, the evaluation may be completed in a residential facility arranged by the provider. Residential evaluations may include a maximum of three days room and board payment and must be prior authorized by the State or its designee.



32-002.09 CCAA Addendum: If the court requests a revised CCAA and the request is within 12 months of the original CCAA, a CCAA addendum may be authorized by the State or its designee. The addendum shall clarify or update the treatment needs and/or recommendations as well as provide information not included in the original CCAA.

32-002.10 Individual Psychotherapy: A face-to-face active treatment session between a client and an appropriately licensed practitioner for the purpose of improving the mental health symptoms that are significantly impairing the client's functioning in at least one life domain such as family, social, occupational or educational.

32-002.10A The treatment plan shall 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 shall be individualized according to the client's needs and the identified symptoms experienced by the client. Services must be treatment focused and not rehabilitative or habilitative in nature.

32-002.10B The following services are not covered:

1. Treatment that is primarily supportive, social or educational in nature.
2. Services for prevention, maintenance, socialization or skill building.

32-002.11 Group Psychotherapy: A face-to-face treatment session between a client and a licensed practitioner in the context of a group setting of 3-12 clients. Group psychotherapy shall 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 client's active treatment plan and there is reasonable expectation that group psychotherapy will improve the client's psychiatric symptoms so that therapy will no longer be needed.

32-002.11A The following services are not covered:

1. Treatment that is primarily supportive, social or educational in nature.
2. Treatment for prevention, maintenance, socialization or skill building.

32-002.12 Family Psychotherapy: A face-to-face treatment session in which an identified client and the client'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. Depending on the clinical appropriateness, it is expected that all members of the family residing in the same household as the client participate in family therapy. Others significant to the client or the family may also be in attendance at Family Psychotherapy if their attendance will be meaningful in improving family functioning.

32-002.12A The following services are not covered:

1. Treatment that is primarily supportive, social or educational in nature.
2. Treatment for prevention, maintenance, socialization or skill building.

32-002.13 Parent Child Interaction Therapy (PCIT): An evidence-based service provided to children age 2-12. This therapy places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns. As such, it is used to treat clinically significant disruptive behaviors due to the child's primary mental health disorder.

32-002.13A The goals, frequency and duration of the service shall be identified in the child's treatment plan and shall 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 PCIT services only after a recent appropriate medical evaluation to rule out conditions of a general medical nature.

32-002.13B There shall be a reasonable expectation that PCIT Therapy will improve the child's psychiatric symptoms so that the services will no longer be necessary.

32-002.13C The following services are not covered:

1. Treatment that is primarily supportive, social or educational in nature.
2. Services for maintenance, socialization or skill building.
3. Services not following the PCIT evidence-based treatment model or performed by an individual not appropriately trained in PCIT.

32-002.14 Child-Parent Psychotherapy (CPP): An evidence-based service provided to children birth to age 5, who have experienced at least one traumatic event (e.g. maltreatment, the sudden or traumatic death of someone close, a serious accident, sexual abuse, exposure to domestic violence) and, as a result, are experiencing behavior, attachment, and/or mental health problems, including post-traumatic stress disorder (PTSD). The primary goal of CPP is to support and strengthen the relationship between a child and his or her parent (or caregiver) as a vehicle for restoring the child's sense of safety, attachment, and appropriate affect and improving the child's cognitive, behavioral, and social functioning.

32-002.14A The goals, frequency and duration of the service shall be identified in the child's treatment plan and shall 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 CPP services only after a recent appropriate medical evaluation to rule out conditions of a general medical nature.

32-002.14B There shall be a reasonable expectation that CPP therapy will improve the child's psychiatric symptoms so that the services will no longer be necessary.

32-002.14C The following services are not covered:

1. Treatment that is primarily supportive, social or educational in nature.
2. Services for maintenance, socialization or skill-building.
3. Services not following the CPP evidence-based treatment model or performed by an individual not appropriately trained in CPP.

32-002.15 Individual Substance Use Disorder Counseling: A face-to-face counseling session between a client and a licensed practitioner for a primary substance use disorder. Individual substance use disorder counseling shall be designed to assist the client in achieving and maintaining abstinence from alcohol and drug abuse. This includes motivational enhancement and interventions defined in the Adolescent Placement Criteria for Level 1 in the American Society of Addiction Medicine (ASAM) Patient Placement Criteria for Treatment of Substance-Related Disorders (current version).

32-002.15A Outpatient substance use disorder counseling shall reasonably be expected to improve the symptoms of the client's substance use disorder which are identified in the client's treatment plan.

32-002.15B The treatment plan shall identify the diagnosis that is the focus of treatment, the specific target symptoms, goals, the frequency and the estimated duration of the service and shall be individualized according to the client's needs and the identified symptoms experienced by the client. Services must be treatment focused and not rehabilitative or habilitative in nature.

32-002.15C The following services are not covered:

1. Services that are primarily supportive, social or educational in nature.
2. Services for prevention, maintenance, socialization or skill building.

32-002.16 Group Substance Use Disorder Counseling: A face-to-face counseling session during which a practitioner directs interactions between 3-12 clients who have a substance use disorder diagnosis for the purpose of all clients achieving abstinence from alcohol and drug abuse.

32-002.16A The definition of group substance use disorder counseling and the criteria for determining whether outpatient group substance use disorder counseling is the most appropriate treatment are listed in the Adolescent Placement Criteria section for Level 1 services in the American Society of Addiction Medicine (ASAM) Placement Criteria for Treatment of Substance Related Disorders (current version).

32-002.16B The following services are not covered:

1. Counseling that is primarily supportive, social or educational in nature.
2. Counseling for prevention, maintenance, socialization or skill building.

32-002.17 Family Substance Use Disorder Counseling: A face-to-face treatment session between an identified client and the client's nuclear or extended family and a licensed practitioner. The services shall focus on the client's substance use disorder needs and the family as a system and shall 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 client participate in family substance use disorder counseling. The specific objectives shall be to increase the functional level of the identified client and the client's family related to substance use.

32-002.17A The service shall be for a client with a substance related disorder and meet the criteria of Level I treatment according to the youth criteria of the Patient Placement Criteria for Treatment of Substance-Related Disorders of the American Society of Addiction Medicine (ASAM).

32-002.17B The following services are not covered:

1. Counseling that is primarily supportive, social or educational in nature.
2. Counseling for prevention, maintenance, socialization or skill building.

32-002.18 Conferences: Conferences with family or other persons advising them on how to assist the client can be covered under limited circumstances.

32-002.18A These circumstances must demonstrate a need for the therapeutic involvement and include:

1. Following Psychiatric Testing, or
2. As required during the provision of MST services, or
3. As a treatment intervention, identified in the client's treatment plan and requiring a progress note.

32-002.18B All conferences must be prior approved by Medicaid or its designee.

32-002.18C Scheduling appointments and reporting client progress are not considered conferences and shall not be reimbursable. Supervisory meetings or care coordination meetings are not conferences and shall not be reimbursable.

32-002.19 Community Treatment Aide Services: Community Treatment Aide (CTA) services are supportive and psychoeducational interventions designed to assist the client 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 client's mental illness that create significant impairments in functioning. The client's CTA plan shall be a part of the comprehensive treatment plan developed by the client's outpatient psychotherapy provider and be developed in close collaboration with the therapy provider. The CTA interventions, the client's progress and modifications to the CTA plan shall be reviewed and approved by the outpatient therapist and shall be documented by the CTA and the therapist.

32-002.19A CTA services shall be provided primarily in the client's natural environment, i.e., home or foster home, but may also include other appropriate community locations where the parent or caregiver are present. CTA services shall not be used in place of a school aide or other similar services not involving the parent.

32-002.19B CTA services shall be delivered under the direction and supervision of the therapist providing family and/or individual therapy on a regular basis to the client and the client's caregiver/family. The CTA and the licensed therapist shall coordinate care and document their collaboration at least every other week to ensure the CTA activities delivered to the client remain relevant to the client's treatment plan.

32-002.19C Activities designed by CTA providers may include activities related to:

1. Developing a written safety plan with input from the therapist, the client and the parents or caregivers.
2. Instructing the parents or caregivers in de-escalation techniques and strategies.
3. Teaching and modeling appropriate behavioral treatment interventions and techniques and coping skills with the client and the client's parents or caregivers.
4. Collecting information about medication compliance and developing reminder strategies and other interventions to enhance compliance as needed.
5. 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.
6. Teaching and modeling proper and effective parenting practices.
7. Providing training and rehabilitation regarding basic personal care and activities of daily living.

32-002.19D CTA services shall be prior authorized by the State or its designee in order to be eligible for reimbursement.

32-002.19E CTA agencies shall have a program description approved by the State or its designee.

32-002.19F The CTA program/clinical director may be a licensed physician (MD or DO) who has completed a psychiatric residency or similar training program and preferably is Board Certified in psychiatry or addiction medicine, psychologist, Licensed Mental Health Practitioner (LMHP), a registered nurse (RN), an APRN or LIMHP. The director shall have two years of professional experience in mental health and/or substance use disorder treatment of individuals under the age of 21.

32-002.19G The CTA therapist shall be a licensed physician (MD or DO) who has completed a psychiatric residency or similar training program and preferably is Board Certified in psychiatry or addiction medicine, psychologist, LIMHP, LMHP or APRN. The CTA may be a PLMHP or a provisionally licensed psychologist only if employed by an accredited organization or by exception by the Department or its designee. The CTA therapist shall meet all the requirements for outpatient therapy and must coordinate and collaborate with the CTA direct staff.

32-002.19H The CTA direct care staff shall:

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

32-002.19I Prior to allowing staff to treat clients, CTA agencies shall gather information from abuse and neglect registries and conduct criminal background checks of all potential CTA workers and shall assure that all workers have completed the CTA agency's basic training program.

32-002.19J The unit of service for CTA staff persons shall be 15 minutes.

32-002.20 Medication Management: Medication management is the service provided by a physician, physician assistant or advanced practice registered nurse focused on the monitoring and prescribing of psychopharmacologic agents. The service shall include relevant history, a mental status examination and medical decision making regarding initiating or adjusting pharmacological agents.

32-002.21 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. The resulting recommendations should also address treatment needs for medical, mental health and/or substance use disorder conditions that are diagnosed during the assessment. The assessment is not a forensic evaluation.

32-002.21A Practitioners providing this assessment shall provide a written report which includes the components listed below that support the treatment recommendations.

32-002.21B The report shall 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.

32-002.21C The components for a sexual offender risk assessment include demographic, biopsychosocial, psychological assessment results and treatment recommendations as follows:

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

32-003 Treatment Crisis Intervention Services: Crisis intervention services are available to clients age 20 or younger when the treatment of a condition needing care leads to a HEALTH CHECK (EPSDT) screen and the treatment is clinically necessary. Crisis intervention services are appropriate for a family in the midst of a child/adolescent mental health or substance abuse crisis. The interventions focus on reducing stress and helping resolve the crisis in a positive manner, and facilitating the client's involvement to treatment.

Crisis intervention services must meet all requirements in 471 NAC 32-001. All crisis intervention service providers must facilitate a referral for a complete HEALTH CHECK (EPSDT) screen within eight weeks of the crisis intervention. This referral must be documented in the client's clinical record.

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

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

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

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

32-003.01 Types of Crisis Intervention Services: One of the following services must be included in a crisis intervention program to be approved for participation in the Nebraska Medical Assistance Program.

32-003.01A Non-Residential Crisis Intervention: Non-residential crisis intervention services are provided to the family and client 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 (see 471 NAC 32-001.04, item 2) who is acting within his/her 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.

Providers of crisis intervention services must facilitate the referral to or provide the Initial Diagnostic Interview if it has not already occurred.

32-003.01B 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 (see 471 NAC 32-001.04) or technicians, under the direction of a supervising practitioner.

Providers of crisis intervention services must facilitate the referral to or provide the Initial Diagnostic Interview if it has not already occurred.

32-003.01C 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 client and facilitate admission to the most appropriate treatment setting. These services must be directed under the cooperative supervision of a physician and other licensed practitioner of the healing arts. The milieu and direct care interventions may be staffed by clinical professionals (see 471 NAC 32-001.04) or technicians, under the direction of a supervising practitioner.

Providers of crisis intervention services must facilitate the referral to or provide the Initial Diagnostic Interview, if it has not already occurred.



32-003.02 Standards for Participation as a Provider of Crisis Intervention Services: Programs shall meet the following standards to participate in the NMAP as a provider of crisis intervention service in addition to the standards listed in 471 NAC 32-001.03.

32-003.02A Provider Agreement: The provider shall submit the following with Form MC-19 (non-hospital) or Form MC-20 (hospital):

1. A written overview of the program's philosophy and objectives of treating youth including:
  - a. A description of each available service;
  - b. A list of treatment modalities available and the capacity for individualized treatment planning;
  - c. A statement of qualification, education, and experience of each staff member providing treatment and the supervising practitioner and the therapeutic services each provides;
  - d. A schedule covering the total number of hours that the program operates;
  - e. A program overview, including admission criteria, staff training information, etc.; and
  - f. Any other information requested by the Department;
2. Copies of licensure and certification, through the Nebraska Department of Health and Human Services, Division of Public Health, JCAHO, COA, AOA and/or CARF as appropriate.

32-003.02B Staffing Standards for Participation: An agency providing crisis intervention services for children and adolescents shall meet the following staffing standards to participate in NMAP:

1. 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 client assessment.
2. Direct intervention services must be provided by a clinical staff person who is acting within his/her scope of practice (see 471 NAC 32-001.04).

32-003.02C Location of Services: Crisis intervention services may be provided in any of the following locations:

1. The client's home;
2. A physician's private office;
3. A community mental health program which meets the criteria for approval by JCAHO or is accredited by CARF, COA, or AOA, and is appropriately licensed by the Nebraska Department of Health and Human Services, Division of Public Health;
4. A hospital licensed and certified by the State of Nebraska which is accredited by JCAHO or AOA and has in effect a utilization review plan applicable to all Medicaid clients;
5. 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;
6. The client's school;
7. Other appropriate locations to meet the client needs for intervention;
8. A treatment foster home that is part of an agency enrolled to provide treatment foster care through Medicaid; or
9. A facility enrolled as a residential treatment center or therapeutic group home under this chapter (Mental Health and Substance Abuse Services for Children and Adolescents).

32-003.02D Annual Update: The provider shall submit the following information on an annual basis:

1. An overview of any changes in the program including any new services;
2. A current list of staff; and
3. Current copies of all licenses, letters of accreditation, and certifications.

32-003.03 Covered Services: Payment for crisis intervention services under the Nebraska Medical Assistance Program is limited to services for clinically necessary psychiatric diagnoses. The Department covers the following crisis intervention services:

1. Active treatment, which must be:
  - a. Provided under the supervision of the supervising practitioner by clinical staff members acting within their scope of practice (see 471 NAC 32-001.04); and
  - b. Reasonably expected to improve the client's condition or resolve the crisis. The treatment interventions must, at a minimum, be designed to reduce or control the client's symptoms to facilitate the resolution of a crisis or prevent the need for care in a more restrictive level of care.

32-003.03A Special Treatment Procedures in Crisis Intervention Services: If a child/adolescent needs behavior management and containment beyond unlocked time outs or redirection, special treatment procedures may be utilized. For Crisis Intervention Services provided in Treatment Foster Care, Residential Treatment Centers, or Treatment Group Homes, please refer to the sections covering those services. For Crisis Intervention Services provided in the child/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 the Department 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:

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

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

32-003.04 Admission Criteria: The provider of crisis intervention services shall develop admission criteria for the types of services they provide. The admission criteria must be approved by the Department Medicaid staff as part of the provider enrollment.

32-003.05 Documentation in Client's Medical Record: Providers of crisis intervention services must follow the standards for Clinical Records specified in 471 NAC 32-001.05.

Clinical records for crisis intervention services must also include, at a minimum, the following:

1. The referral source and description of the crisis;
2. The provider's plan to facilitate referrals to the appropriate ongoing care for the family; and
3. The follow-up contacts with the client and/or family.

32-003.06 Limitations: NMAP limits payment for crisis intervention to medically necessary services, subject to the Department'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 client's condition dictates. Payment for crisis intervention services is not available for services past seven days.

32-003.07 Payment for Crisis Intervention Services: Payment for crisis intervention services is made according to the Nebraska Medicaid Practitioner Fee Schedule at 471-000-532.

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.

32-004 Mental Health and Substance Use Disorder Day Treatment Services: Day treatment services are available to clients age 20 or younger when the client has participated in a HEALTH CHECK (EPSDT) screen, the treatment is clinically necessary, and the need for this level of care is identified as part of a Substance Use Disorder Assessment. These services are part of a continuum of care designed to prevent hospitalization or to facilitate the movement of the client in an acute psychiatric setting to a status in which the client is capable of functioning within the community with less frequent contact with the mental health or substance abuse provider.

Day treatment services must be community based, family centered, culturally competent, and developmentally appropriate.

Day treatment services must meet all requirements in 471 NAC 32-001.

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

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

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

32-004.01 Covered Day Treatment Services: Day treatment programs shall 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 client 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 shall not make any additional charges to the Department or to the client.

32-004.01A Mandatory Services: The following services must be included in a program for day treatment to be approved for participation in the Nebraska Medical Assistance Program. See 471 NAC 32-001 for definitions.

1. Medically Necessary Psychotherapy and Substance Abuse Counseling Services: These services must demonstrate active treatment of a patient with a serious emotional disturbance. These services are subject to program limitations.
  - a. Individual Psychotherapy or Substance Abuse Counseling;
  - b. Group Psychotherapy or Substance Abuse Counseling;
  - c. Family Psychotherapy or Substance Abuse Counseling; and
  - d. Family Assessment;
2. Medically Necessary Nursing Services: Medical services provided by a Qualified Registered Nurse who evaluates the particular medical nursing needs of each client and provides for the medical care and treatment that is indicated on the Department approved treatment planning document and approved by the supervising practitioner.
3. Medically Necessary Psychological Diagnostic Services: Testing and evaluation services must reasonably be expected to contribute to the diagnosis and plan of care established for the individual client. Testing and evaluation services may be performed by a Licensed Psychologist, Specially Licensed Psychologist or a psychology resident acting within his/her scope of practice. Clinical necessity must be documented by the program supervising practitioner. Reimbursement for psychological diagnostic services is included in the per diem.
4. Medically Necessary Pharmaceutical Services: If medications are dispensed by the program, pharmacy services must be provided under the supervision of a registered pharmacy consultant; or the program may contract for these services through an outside facility or provider. All medications must be stored in a special locked storage space and administered only by a physician, registered nurse, or licensed practical nurse.
5. Medically Necessary Dietary Services: If meals are provided by a day treatment program, services must be supervised by a registered dietitian, based on the client's individualized diet needs. Day treatment programs may contract for these services through an outside facility or provider.
6. Transition and discharge planning that meets the requirements of 471 NAC 32-001.07A.

32-004.01B Optional Services: The program must provide two of the following optional services. The client must have a need for the services, the supervising practitioner must order the services, and the services must be a part of the client's treatment plan. The therapies must be restorative in nature, not prescribed for conditions that have plateaued or cannot be significantly improved by the therapy, or which would be considered maintenance therapy. In appropriate circumstances, occupational therapy may be covered if prescribed as an activities therapy in a day treatment program:

1. Services provided or supervised by a licensed or certified therapist may be provided under the supervision of a qualified consultant or the program may contract for these services from a licensed/certified professional as listed below:
  - a. Recreational Therapy;
  - b. Speech Therapy;
  - c. Occupational Therapy;
  - d. Vocational Skills Therapy;
  - e. Self-Care Services: Services supervised by a registered nurse or occupational therapist who is oriented toward activities of daily living and personal hygiene. This includes toileting, bathing, grooming, etc.
2. Psychoeducational Services: 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 abuse 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.
3. 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, i.e., case management type services.
4. Crisis Intervention (may be provided in home);
5. Social Skills Building;
6. Life Survival Skills; and
7. Substance abuse prevention, intervention, or treatment by an appropriately certified alcohol/drug abuse counselor.

32-004.01C Educational Program Services: 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 the Nebraska Medical Assistance Program (Medicaid), and do not apply towards the three hours or six hours of therapeutic services.

32-004.01D Special Treatment Procedures in Day Treatment: If a child/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 the Department 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:

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

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

#### 32-004.02 Standards for Participation

32-004.02A Provider Standards: Providers of day treatment services shall meet the following standards:

1. A community mental health or substance abuse program providing day treatment must meet the following standards -
  - a. A community-based treatment facility appropriately licensed as determined by the Department of Health and Human Services, Division of Public Health;



- b. Accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), 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; and
2. A psychiatric or substance abuse hospital providing day treatment must -
  - a. Be maintained for the care and treatment of patients with primary psychiatric or substance abuse disorders;
  - b. Be licensed or formally approved as a hospital by the Nebraska Department of Health and Human Services, Division of Public Health;
  - c. Be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Association (AOA);
  - d. Have licensed and certified psychiatric or substance abuse beds;
  - e. Meet the requirements for participation in Medicare; and
  - f. Have in effect a utilization review plan applicable to all Medicaid clients.
3. A licensed and certified hospital which provides acute care services and which -
  - a. Is maintained for the care and treatment of patients with acute medical disorders;
  - b. Is licensed or formally approved as a hospital by the Nebraska Department of Health and Human Services, Division of Public Health;
  - c. Is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Association (AOA);
  - d. Meets the requirements for participation in Medicare for acute medical hospitals;
  - e. Has in effect a utilization review plan applicable to all Medicaid clients; and
  - f. Has adequate staff to meet the requirements of the mental health or substance abuse day treatment standards.
4. If day treatment services will be provided in a school, the school must have a written contract with a mental health or substance abuse program that meets these standards community mental health program or licensed hospital. This contract shall demonstrate the working relationship between the school and the community mental health or substance abuse program to provide the day treatment service.

32-004.02B Service Standards:

1. The program must provide a minimum of three hours of services five days a week, which is considered a half day for billing purposes. Six hours a day of services is considered a full day of services. Services may not be prorated for under three (or six) hours of services, but may be for up to 12 hours of service.
2. 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 clients. 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 (see 471 NAC 32-001.04) shall assume delegated professional responsibility for the program and must be present at all times when the program is providing services.  
Psychotherapy and substance abuse counseling services must be provided by clinical staff (see 471 NAC 32-001.04) 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 client's clinical record.
3. A licensed psychologist, physician, or doctor of osteopathy may refer a client to a day treatment program, but all treatment must be prescribed and directed by the program supervising practitioner.
4. All treatment must be conducted under the direction of the supervising practitioner in charge of the program;
5. Admission Criteria: The following criteria must be met for a client's admission to a day treatment program:
  - a. The client must have sufficient need for active treatment at the time of admission to justify the expenditure of the client's and program's time, energy, and resources;
  - b. Of all reasonable options for active treatment available to the client, treatment in this program must be the best choice for expecting a reasonable improvement in the client's condition;
6. Before the client is admitted to the program, a supervising practitioner shall complete an Initial Diagnostic Interview to validate the appropriateness of care.
7. Treatment Plan: The program supervising practitioner shall determine the diagnosis and prescribe the treatment, including the modalities and the professional staff to be used. He/she must be responsible and accountable for all evaluations and treatment provided to the client.

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

The multi-disciplinary team shall complete the treatment plan within the first 14 days after the client'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.

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.

8. The supervising practitioner must meet personally with the client 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.
9. Every 30 days a utilization review must be conducted per 471 NAC 32-004.07. 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 client was admitted.
10. The program must have a description of each of the services and treatment modalities available. This includes psychotherapy services, substance abuse counseling, nursing services, psychological diagnostic services, pharmaceutical services, dietary services, and other day treatment services.
  - a. The program must have a description of how the family-centered requirement in 471 NAC 32-001 will be met, including a complete description of any family assessment and family services.
  - b. The program must have a description of how the community-based requirement in 471 NAC 32-001 will be met.
  - c. The program shall state the qualifications, education, and experience of each staff member and the therapy services each provides.
  - d. The program must have a daily schedule covering the total number of hours the program operates per day. The schedule must be submitted to the Department for approval. The program must be fully staffed and supervised during the time the program is available for services, and must provide at least three hours of approved treatment for each day services are provided. This schedule must be updated annually, or more frequently if appropriate.

11. Outpatient Observation: When appropriate for brief crisis stabilization, outpatient observation up to 23 hours 59 minutes in an emergency room or acute hospital may be used as follows:  
An outpatient is defined as a person who has not been admitted as an inpatient but is registered on the hospital records as an outpatient and receives services (rather than supplies alone). If a patient receives 24 or more hours of continuous outpatient care, that patient is defined as an inpatient regardless of the hour of admission, whether s/he used a bed and whether s/he remained in the hospital past midnight or the census-taking hour, and all inpatient prior-authorization requirements apply.
12. 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 abuse hospital or distinct part of a hospital, as outlined in 471 NAC 32-008. A copy of this agreement must accompany the provider application and agreement.

32-004.03 Provider Agreement: A provider of day treatment services shall complete a provider agreement and submit the form to the Department for approval. The provider shall attach to the provider agreement a written overview of the program including philosophy, objectives, policies and procedures, and documentation of the requirements in 471 NAC 32-001 are met. Staff must meet the standards outlined in 471 NAC 32-001.04, and:

1. Community mental health or substance abuse programs and licensed health clinics shall complete Form MC-19, "Medical Assistance Provider Agreement," and submit the completed form to the Department for approval. A Department approved cost reporting document must also be submitted. Satellites of community programs shall bill the Department 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 shall complete a separate provider agreement. All claims submitted to the Department by these satellites must be filed under the satellite's Medicaid provider number. The facility must have in effect a utilization review plan applicable to all Medicaid clients.
2. Hospitals shall complete Form MC-20, "Medical Assistance Hospital Provider Agreement," and submit the completed form to the Department for approval. A Department approved cost reporting document must also be submitted.

32-004.03A Annual Renewal/Update: The program shall renew the provider agreement, program overview, and cost report annually and whenever requested by the Medicaid Division.

32-004.04 Coverage Criteria for Mental Health or Substance Abuse Day Treatment Services:

The Nebraska Medical Assistance Program covers day treatment services for clients 20 and younger when the services meet the requirements in 471 NAC 32-001 and the client has participated in a HEALTH CHECK (EPSDT) screen.

Day treatment services must be prior authorized by the Division of Medicaid and Long-Term Care or its designee.

The client 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 client's clinical record.

32-004.04A Services Not Covered Under NMAP: Payment is not available for day treatment services for clients -

1. Receiving services in an out-of-state facility, except as outlined in 471 NAC 1-002.01F, Services Provided Outside Nebraska;
2. In long term care facilities;
3. Whose needs are social or educational and may be met through a less structured program;
4. 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
5. Whose behavior may be very disruptive and/or harmful to other program participants or staff members.

32-004.05 Documentation in the Client's Clinical Record: All documents submitted to NMAP must contain sufficient information for identification (i.e., client's name, dates of service, provider's name). In addition to the requirements of 471 NAC 32-001.05, each client's medical record must contain the following documentation:

1. The supervising practitioner's orders;
2. The treatment plan;
3. The team progress notes, recorded chronologically. The frequency is determined by the client's condition, but the team's progress notes must be recorded at least daily. The progress notes must contain a concise assessment of the client's progress and recommendations for revising the treatment plan, as indicated by the client's condition, and discharge planning.
4. Documentation indicating compliance with all requirements in 471 NAC 32-001;
5. Records of the treatment plan review by the multi-disciplinary team including attendees and decisions;
6. The program's utilization review committee's abstract or summary; and
7. The discharge summary.

32-004.06 Transition and Discharge Planning: Each provider must meet the 471 NAC 32-001.07A requirements for transition and discharge planning.

32-004.07 Utilization Review (UR): Each program is responsible for establishing a utilization review plan and procedure which meets the following guidelines. A site visit by Medicaid staff for purposes of utilization review may be required for further clarification.

32-004.07A Components of UR: Utilization review must provide -

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

32-004.07B UR Overview: An overview of the program's utilization review process must be submitted with the provider application and agreement before the program is enrolled as a Medicaid provider. The overview must include -

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

32-004.07C UR Committee: The utilization review committee must contain a licensed practitioner of the healing arts 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 471 NAC 32-001). The committee's reviews may not be conducted by any person whose primary interest in or responsibility to the program is financial or who is professionally involved in the care of the client whose case is being reviewed. At the Department's discretion, an alternative plan for facilities that do not have these resources readily available may be approved.

32-004.07D Basis of Review: The review must be based on -

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

32-004.07E Contents of Report: The written report must contain -

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

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

32-004.08 Limitations on Reimbursement of Allowable Costs: The following limitations apply to reimbursement of allowable costs:

1. Payment for a full day of day treatment is allowable when services are provided to a client for at least six hours per day.
2. Payment for a half day of day treatment is allowable when services are provided to a client 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.
3. 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, NMAP will pay an additional amount based on the cost-report.

32-004.08A Documentation for Claims: The following documentation is required for all claims for day treatment/claims and must be kept in the client's record:

1. A psychiatric assessment with mental status exam and diagnosis;
2. The treatment plan, if required (required at admission and every 30 days thereafter);
3. Orders by the supervising practitioner;
4. A complete family assessment;
5. Nurses' notes; and
6. Progress notes for all disciplines.

All claims are subject to utilization review by the Department prior to payment.

32-004.08B Exception: Additional documentation from the client's medical record may be requested by the Department prior to considering authorization of payment.

32-004.08C Costs Not Included in the Day Treatment Fee: The mandatory and optional services are considered to be part of the fee for day treatment services. The following charges can be reimbursed separately from the day treatment fee when the services are necessary, part of the client's overall treatment plan, and in compliance with NMAP policy:

1. Direct client services performed by the supervising practitioner;
2. Prescription medications (including injectable medications);
3. Direct client services performed by a physician other than the supervising practitioner; and
4. Treatment services for a physical injury or illness provided by other professionals.

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

32-004.09 Procedure Codes and Descriptions for Mental Health or Substance Abuse Day Treatment: HCPCS/CPT procedure codes used by NMAP are listed in the Nebraska Medicaid Practitioner Fee Schedule at 471-000-532.



32-005 Treatment Foster Care Services: Treatment foster care services are available to clients age 20 or younger when the client has participated in a HEALTH CHECK (EPSDT) screen, the treatment is clinically necessary, and an Initial Diagnostic Interview documents the need for continued care of this level. Treatment foster care occurs in a foster home when specially trained foster parents are available at all times to provide consistent behavior management programs, therapeutic interventions, and render services under the direction of a supervising practitioner. Treatment foster 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 client/family's adjustment emotionally, behaviorally, socially, and educationally. To be eligible to receive treatment in a treatment foster care program, the client must participate in a HEALTH CHECK (EPSDT).

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

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

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

32-005.01 Definitions: The following definitions and descriptions apply to treatment foster care services:

Agency Staff: Treatment foster care requires agency staff who are qualified, trained, and supported to implement the treatment model. Some treatment foster care initiatives have been undertaken in which one or a few staff with duties in other program areas assume responsibility for additional treatment foster care cases. Such arrangements tend to dilute the time, resources, and support available to the TFC Specialist and to the intensity and focus of the services provided. This does not constitute a true program of treatment foster care. A treatment foster care program must have an adequate number of staff to provide administration and direct services. See 471 NAC 32-001.04 for further staff requirements.

Children and Adolescents: Treatment foster care serves clients age 20 or younger whose special needs cannot be met in their own families and who require out-of-home care. In addition to providing treatment for specific problems or conditions, treatment foster care seeks to promote a permanent family living arrangement for the children and youth it serves.

Family Treatment: Treatment foster care programs also serve the families of the children and adolescents in their care. Treatment foster care programs seek to involve children and families in treatment-planning and decision making as members of the treatment team. They provide family services to children and their families when return home is planned, and actively seek to support and enhance children's relationships with their parents, siblings, and other family members throughout the period of placement regardless of the permanency goal unless such efforts are expressly and legally prohibited.

TFC Program: A program of treatment foster care is a coherent, integrated constellation of services specifically designed to provide treatment within the foster home setting. The term program implies a discreet organizational entity with clearly stated purposes and means of achieving them which are logically described and justified within the framework of a consistent treatment philosophy. As a program, treatment foster care is agency lead and team oriented.

Treatment: Treatment is the coordinated and planned provision of services and use of procedures designed to produce a planned outcome in a person's behavior, attitude, or general condition based on a thorough assessment of possible contributing factors. Treatment typically involves the teaching of adaptive, pro-social skills and responses which equip young persons and their families with the means to deal effectively with conditions or situations which have created the need for treatment. The term treatment presumes stated, measurable goals based on professional assessment, a set of written procedures for achieving them, and a process for assessing these results. Treatment accountability requires that goals and objectives be time limited and outcomes systematically monitored.

Treatment Foster Family: The treatment foster family is viewed as the primary treatment setting, with treatment parents trained and supported to implement the in-home portion of the treatment plan and promote the goals of permanency planning for children in their care. The treatment foster parents provide the main behavioral intervention and are available at all times. (At least one TFC parent per home must be considered a professional TFC parent whose time is dedicated to the TFC program.) While their role is essential to the model, treatment parents do not carry primary or exclusive responsibility for the design of treatment plans. This is a team function carried out under the clinical direction of qualified program staff.

32-005.02 Standards of Participation for Service Providers: The Nebraska Medical Assistance Program does not pay for care that is chronic or custodial. An agency that provides treatment foster care services shall meet the following standards for participation to ensure that payment is made only for active treatment:

1. The agency shall meet the standards in 471 NAC 32-001 and 471 NAC 32-005;
2. The treatment foster homes shall meet the minimum regulations for foster homes caring for children and be licensed through the Department (see 474 NAC 6-003) or approved by the placing agency;

3. The agency providing treatment foster care must be licensed as a Child Placing Agency (see 474 NAC 6-005);
4. The agency's records must be sufficient to permit the Department to determine the degree and intensity of treatment services furnished to the client/family;
5. The agency shall meet staffing requirements the Department finds necessary to carry out an active treatment program;
6. The program is designed to meet the developmental needs of persons age 20 and younger;
7. The program must provide for both planned and unplanned respite care services; and
8. The place of service must be the treatment foster family home.

32-005.02A Provider Agreement: A provider of treatment foster care (TFC) services shall complete a provider agreement, Form MC-19 or Form MC-20, "Medical Assistance Provider Agreement," and submit the completed form along with a program plan to the Department for approval. The provider application and agreement must be renewed annually to coincide with the submittal of the cost report (see 471 NAC 32-005.09).

An outline of the information required in a program plan is available from the Division of Medicaid and Long-Term Care.

If an agency providing treatment foster care is licensed, certified, or accredited through another agency (Department of Health and Human Services, Division of Public Health, Joint Commission on Accreditation of Health Care Organizations (JCAHO), etc.), the provider shall maintain this and provide a current copy for verification.

Agencies providing treatment foster care must be appropriately licensed by the Department of Health and Human Services, Division of Public Health.

32-005.02B Annual Renewal/Update: The program will submit information with the provider agreement (see 471 NAC 32-005.02A) and update the information annually and whenever requested by the Division of Medicaid and Long-Term Care.

32-005.03 Guidelines for Use of the Treatment Foster Care Services for Children: A youth must have a diagnostic condition listed in the current diagnostic and statistics manual of the American Psychiatric Association (excluding V-codes and developmental disorders) for this level of care. NMAP applies the following general guidelines to determine when treatment foster care services for children are clinically necessary for a client:

1. Utilization of treatment foster care is appropriate for individualized treatment and is expected to improve the client's condition to facilitate moving the client to a less restrictive placement;
2. The child/youth's problem behaviors are persistent but can be managed with this moderate level of structure;
3. The child/youth's daily functioning is moderately impaired in such areas as family relationships, education, daily living skills, community, health, etc.;
4. The child/youth has a history of previous problems due to ongoing inappropriate behaviors or psychiatric symptoms; or
5. Less restrictive treatment approaches have not been successful (see 42 CFR 441.152) or are deemed inappropriate by the supervising practitioner or treatment in a more restrictive setting has helped stabilize the client's behavior or psychiatric symptoms and they are ready to transition to a less restrictive level of care.

#### 32-005.04 Staffing Standards for Participation

32-005.04A Staff Members: The following staff positions must be included in a treatment foster care program description. All staff must be operating within the scope of practice guidelines established by the Nebraska Department of Health and Human Services, Division of Public Health; alcohol and drug abuse counselors are licensed by HHS.

32-005.04A1 TFC Supervisor: The role of the TFC supervisor is to provide support and consultation to the treatment team and caseworker.

1. TFC supervisor responsibilities are -
  - a. TFC Specialist supervision: The TFC supervisor will provide regular support and guidance to the caseworker through regular supervisory meetings and informal contact as needed. This TFC supervisor/specialist ratio must not exceed 1 to 6 and must be adjusted to accommodate for variables such as the severity of clients served or by the experience/qualifications of the casework staff.
  - b. Treatment planning: The TFC supervisor is a member of the treatment team and shares the responsibilities of developing the plan. S/he also evaluates progress reports and updates.
  - c. Crisis on-call: The TFC supervisor provides coordination and back-up to ensure that 24-hour on-call crisis intervention services are available and delivered to treatment families and client families.
  - d. Other: May include but is not limited to any of the following:
    - (1) Case management;
    - (2) Case assessment;
    - (3) Parent support and consultation;
    - (4) Clinical and administrative supervision of staff;
    - (5) Treatment parent recruitment;
    - (6) Orientation;
    - (7) Training and selection;
    - (8) Youth intake and placement;
    - (9) Record keeping;
    - (10) Program evaluation;
2. TFC supervisor activities must be performed by a clinical staff member as defined in 471 NAC 32-001.04 who is acting within his/her scope of practice.

32-005.04A2 TFC Specialist: The TFC specialist is the practical leader of the treatment team and works in development of the treatment plan, supports and consults with the treatment families, client families, and other members of the treatment team. The TFC specialist also advocates for, coordinates, and links treatment families and client families to other services available in the community.

1. TFC specialist responsibilities:
  - a. Treatment team:
    - (1) Under the direction of the supervising practitioner and the TFC supervisor, the TFC specialist takes primary day-to-day responsibility for leadership of the treatment team. The TFC specialist organizes and manages all team meetings and team decision making. The TFC specialist takes an active role in identifying goals and coordinating treatment services provided to the youth.
    - (2) The TFC specialist provides information and training to treatment team members who may not be familiar with the treatment foster care model. The TFC specialist prepares these individuals to work with treatment parents and client families in a manner which is supportive of their roles. The TFC specialist also prepares them to work with the team in a manner consistent with the treatment foster care practice and values.
  - b. Treatment planning: The TFC specialist takes primary responsibility for the preparation of each client/family's written comprehensive treatment plan and the written updates of the plan. The TFC specialist seeks to inform and involve other team members in this process including treatment parents and the client family.
  - c. Support/consultation to treatment parents:
    - (1) The TFC specialist will provide regular support and technical assistance to the treatment parents in their implementation of the treatment plan and with regard to other responsibilities they undertake. The fundamental components of technical assistance will be the design or revision of in-home treatment strategies including proactive goal setting and planning, the provision of ongoing child-specific skills training, and problem solving during home visits.

- (2) Other types of support/supervision include emotional support and relationship building, the sharing of information and general training to enhance professional development, assessment of the client's progress, observation/assessment of family interactions and stress, and assessment of safety issues. The TFC specialist will provide at least weekly contact by phone or in person with the treatment parent of each client family on his/her caseload. The TFC specialist will visit the treatment home to meet with at least one TFC parent no less than twice per month, or more often as is necessary.
  - d. Caseload: The number of client/families assigned to a TFC specialist is a function of: the size/density of the geographic area, the array of job responsibilities assigned, and the difficulty of the population served. The preferred maximum number of youth that may be assigned to a single TFC specialist is ten (individuals or siblings strips). (Flexibility within this standard is possible and will be considered on an individual program basis.)
  - e. Contact with client/family: The TFC specialist or other program staff shall regularly spend time alone with the client/families to allow them opportunity to communicate special concerns, to make direct assessment of their progress, and to monitor for potential abuse. The face-to-face contact must occur monthly, or more often based on the current needs of the client/family and the treatment parents and applies on an individual client/family basis.
  - f. Support/consultation of the client/families: The TFC specialist will seek support and enhance the client's relationships with his/her family during his/her time in treatment foster care. The TFC specialist will arrange and encourage regular contact and visitation as specified in the treatment plan. The TFC specialist will seek to include the client/family in treatment team meetings, treatment planning, and decision making, and will keep them informed of the client's progress.
  - g. Community liaison and advocacy: The TFC specialist will work with the treatment team to determine which community resources will help meet the needs of the client/families to meet the objectives of the treatment plan. The TFC specialist will advocate for and coordinate these services while providing technical assistance to the community agency.
  - h. Crisis on-call: The TFC specialist will work with other professionals on the team to coordinate 24-hour crisis coverage.
2. TFC specialist activities must be performed by a clinical staff member as defined in 471 NAC 32-001.04 who is acting within his/her scope of practice.

32-005.04A3 Other Members of the Agency Staff: These are recommended parts of the agency staff and several areas may be covered by one staff member:

1. Staff development and training;
2. Administrative support;
3. Consultants, including -
  - a. Psychiatrist;
  - b. Psychologist;
  - c. Educational;
  - d. Substance abuse;
  - e. Sexual abuse;
  - f. Family systems;
  - g. Recreation therapist; and
  - h. Legal; and
4. Respite care staff.

32-005.04A4 Supervising Practitioner: The role of the supervising practitioner is to support and supervise the treatment team in providing active treatment to the client/family.

1. The supervising practitioner must be a licensed practitioner of the healing arts who is able to diagnose and treat major mental illness within his/her scope of practice and must maintain this licensure in the state in which the program operates (see 471 NAC 32-001.04, Staffing Standards);
2. Supervising practitioner responsibilities:
  - a. Treatment team participation: The supervising practitioner will provide regular support and guidance to the treatment team through team meetings;
  - b. Treatment planning: The supervising practitioner helps in the development of a comprehensive treatment plan based on a thorough assessment for each client/family admitted to the program and input provided by the multidisciplinary team. S/he also participates in ongoing treatment planning and implementation for each client/family, as appropriate;
  - c. Crisis on-call: The supervising practitioner provides consultation for on-call staff and foster parents. The supervising practitioner also helps coordinate emergency psychiatric hospitalizations when necessary and works with or is the admitting physician; and
  - d. Client contact: The supervising practitioner will meet with the client/family as described in the treatment plan to assess the client's needs and monitor progress toward goals.

32-005.04B Staff Training and Support: All professional staff require preservice and ongoing professional development relevant to the treatment foster care model and to their individual job responsibilities. The staff training plan must be approved by the Department.

32-005.04B1 Crisis On-Call: The program shall provide on-call crisis intervention support to supplement that provided by the TFC supervisor and specialist to allow for 24-hour coverage and to avoid staff burnout.

32-005.04B2 Liability Insurance: Professional staff must be covered by liability insurance.

32-005.04B3 Legal Advocacy and Representation: The agency shall assist staff in obtaining legal advocacy and representation should the need arise in connection with the proper performance of their professional duties.

32-005.04B4 Respite Care: The program shall provide for planned and unplanned respite care for clients and treatment foster parents.

32-005.04C Treatment Parents: Treatment parents are members of the treatment team whose primary responsibility is to implement the specific strategies of the treatment plan. Their responsibilities also include providing parenting duties as outlined in state and agency regulations concerning foster parents. A treatment parent must be available 24 hours a day to respond to crisis or emergency situations. This may preclude one of the foster parents from working outside of the home. Treatment parents may not provide day care for children in their home.

32-005.04C1 Treatment Parent Responsibilities:

1. Foster role: Treatment duties encompass the basic parenting duties typically required of foster parents. These include, but are not limited to -
  - a. Nutrition;
  - b. Clothing;
  - c. Shelter and physical care;
  - d. Nurturance and acceptance;
  - e. Supervision; and
  - f. Transportation;
2. Treatment planning: The treatment parents shall assist the team in development of treatment plans for the client/family in their care. Treatment parents contribute vital input based upon their observations of the client/family in the natural environment of the treatment home;
3. Treatment implementation: The treatment parents have the primary responsibility for implementing the interventions identified in the treatment plan;



4. Treatment team meetings: The treatment parents shall work cooperatively with other team members and will attend team meetings, training sessions, and other meetings required by the program by the child's treatment plan;
5. Record keeping: The treatment parent shall systematically record information and document activities as required by the agency and the standards under which it operates. The treatment parent shall keep a systematic record of the client/family's behavior and progress in targeted areas on a daily basis (or more often as medically necessary);
6. Contact with child's family: The treatment parent shall assist the client in maintaining contact with his/her family and work actively to enhance and support these relationships as identified in the treatment plan;
7. Permanency planning assistance: The treatment parent shall assist with efforts specified by the treatment team to meet the child's permanency planning goals. These must include, but are not limited to -
  - a. Emotional support;
  - b. Advice;
  - c. Demonstration of effective child behavior management and other therapeutic interventions to the child's family; and
  - d. Support to the child and family during the initial period of post-treatment foster care placement.
8. Community relations: The treatment parent shall develop and maintain positive working relationships with service providers in the community such as schools, departments of recreation, social service agencies, and mental health programs and professionals;
9. Advocacy: The treatment parent shall work with other members of the treatment team to advocate on behalf of the child/family to achieve the goals identified in the treatment plan. This includes obtaining educational, vocational, medical, and other services needed to implement the treatment plan and to assure full access to and provision of public services to which the child is legally entitled; and
10. Notice of request for child move: Unless a move is required to protect the health and safety of the child or other treatment family members, the treatment parent shall provide at least 14 days' notice to program staff if requesting a child's removal from the home so as to allow for a planful and minimally disruptive transition.

32-005.04C2 Treatment Parent Selection: Treatment parents are selected in part on the basis of their acceptance of the program's treatment philosophy and their ability to practice or carry out this philosophy on a daily basis. They must be willing to accept the intense level of involvement and supervision provided by the treatment team in their treatment parenting functions and the impact of that involvement on their family life. Treatment parents must be willing to carry out all tasks specified in their treatment foster care program's job description including working directly and in a supportive fashion with the families of children placed in their care.

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

32-005.04C3 Treatment Parent Training: Treatment parent training must be a systematic, planned, and documented process which includes competency-based skill training and is not limited to the provision of information through didactic instruction. Training must be consistent and with the program's treatment philosophy and methods. It should prepare treatment parents to carry out their responsibilities as agents to the treatment process. The Treatment Parent and Respite Care staff training curriculum must be approved by the Department. The training must include the following components:

1. Preservice training: Prior to the placement of children in their homes, all treatment parents must complete the following training requirements:
  - a. Basic: Treatment parents must satisfactorily complete the preservice training required of all foster parents; and
  - b. Agency specific: 20 hours of agency specific primarily skill-based training consistent with the agency's treatment methodology and the service needs of the child.
2. In-service training: Each treatment parent must have a written educational plan, developed by the treatment foster care parent and their supervisors, on record which describes the content and objectives of in-service training. All treatment parents must complete a minimum of 12 hours of in-service training annually based on the specific training needs identified in the development plan and specific services treatment parents are required to provide. In-service training must emphasize skill development as well as knowledge acquisition and may include a variety of formats and procedures including in-home training provided by agency casework staff.

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

32-005.04C4 Treatment Parent Support: Treatment foster care programs are obligated to provide intensive support, technical assistance, and supervision to all treatment parents. This must include specific management and supervision services in addition to those listed below:

1. Information disclosure: All information the treatment foster care program receives concerning a client/family to be placed with a treatment family must be shared with and explained to the prospective TFC family prior to placement. Treatment parents have access to full disclosure of information concerning the child as well as the responsibility to maintain agency standards of confidentiality regarding such information. The information must include, but is not limited to -
  - a. The child's strengths and assets;
  - b. Potential problems and needs; and
  - c. Initial intervention strategies for addressing these areas.
2. Respite: Respite care must be available at both planned and crisis times. The respite care provider must be trained according to the standards set by the treatment foster care program. The respite care providers must be informed of the client/family treatment plan and supervised in their implementation of the specific in-home strategies. There is no additional payment for respite care as this is a cost that must be included in the annual cost report.
3. Other support (the cost of these supports must be included in the cost report):
  - a. Counseling: During their tenure as Treatment Families, treatment families must have access to counseling and therapeutic services arranged by the treatment foster care program for personal issues or problems caused or exacerbated by their work as treatment families. These issues may include marital stress or abuse of their own children by a client/family in their care.
  - b. Peer support: The treatment foster care program shall facilitate the creation of support networks for treatment foster families (these may include formal groups, informal meetings, of "buddy" systems).
  - c. Financial support: The treatment foster care program financial support to treatment parents must cover the cost of care associated with their treatment responsibilities and special needs of the client/family. The additional financial support given to treatment parents is directly related to the special skills, functions, and responsibilities required of them in fulfilling their roles as treatment parents. This is above and beyond the payment covering room, board, and care costs.

- d. Damages and liability: The treatment foster care program shall have a written plan concerning compensation for damages done to a treatment family's property by client/families placed in their care. This plan must be provided as part of their preservice orientation. The agency shall provide liability coverage or assist the treatment family in obtaining it. Treatment foster parents are required to show documentation of coverage for home/apartment, vehicle (if appropriate), property, and liability insurance in addition to any coverage provided by or through the treatment foster care program.
- e. Legal advocacy: The treatment foster care program shall assist treatment parents in obtaining legal advocacy for matters associated with the proper performance of their role as treatment parents.

32-005.05 Covered Services for Treatment Foster Care: Payment for treatment foster care services under the Nebraska Medical Assistance Program is limited to payment for necessary treatment services for diagnosable conditions. Medicaid shall pay for treatment provided to ameliorate or correct the diagnosed condition. Medicaid does not make payment for care that is primarily chronic or custodial in nature.

32-005.05A Coverage Criteria: The Department covers treatment foster care services when the following criteria are met. The services must be -

- 1. Active Treatment, which must be -
  - a. Treatment provided under a treatment plan developed by the multidisciplinary treatment team based on a thorough evaluation of the client's restorative needs and potentialities, including the developmental needs of clients age 20 or younger. The multidisciplinary treatment team includes the supervising practitioner, the TFC specialist, the TFC parent, and other staff as necessary. The treatment plan must be retained in the client's record.

The treatment plan must be completed within 14 days of the client's admission to treatment foster care. The goals and objectives documented on the treatment plan must reflect the recommendations from the Initial Diagnostic Interview, the supervising practitioner and the therapist. The treatment interventions provided must reflect these recommendations, goals, and objectives. Evaluation of the treatment plan by the therapist and the supervising practitioner should reflect the client's response to the treatment interventions based on the recommendations, goals and objectives.
  - b. Reasonably expected to improve the client's medical condition or to determine a diagnosis. The treatment must, at a minimum, be designed to correct or ameliorate the client's symptoms to facilitate the movement of the client to a less restrictive environment within a reasonable period of time.
  - c. Consistent with the requirements listed in 471 NAC 32-001.06.

2. Necessary Treatment Services, which must be an appropriate level of care based on documented evaluations, including a comprehensive diagnostic work up and team-ordered treatment.
3. Generally limited to one treatment child per home, or one sibling strip of up to two children. Programs may place more than one child or sibling strip of more than two only after specific review by the treatment team and prior authorization through the Division of Medicaid and Long-Term Care.
4. Therapeutic passes for client involved in TFC. Therapeutic passes are an essential part of the treatment for client/families involved in treatment foster care. Documentation of the client's continued need for treatment foster care must follow overnight therapeutic passes. Therapeutic passes must be indicated in the treatment plan as they become appropriate. NMAP reimburses for only 60 therapeutic pass days per client, per year. This includes all treatment services in which the client is involved during the year.

Therapeutic leave days are counted by the entity reimbursing for the care. Because the NMAP fee-for-service program reimburses for therapeutic leave days on a post-service basis and because providers have one year to bill for services, the Department cannot guarantee that an accurate account of the therapeutic leave days that have been used.

In the event that a client does require hospitalization while in treatment foster care, NMAP will reimburse the treatment program for up to 15 days per hospitalization. This reimbursement is only available if the treatment placement is not used by another client.

32-005.05B Special Treatment Procedures in Treatment Foster Care: If a child/adolescent needs behavior management and containment beyond time outs or redirection, special treatment procedures may be utilized. Special treatment procedures in treatment foster care is limited to physical restraint. Mechanical restraints and pressure point tactics are not allowed. Parents or legal guardian or the Department case manager must approve use of this procedure through informed consent and must be informed within 24 hours each time they are used.

Treatment Foster Care Programs must meet the following standards regarding special treatment procedures:

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

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

32-005.06 Intake Process: Treatment foster care services are available to clients age 20 or younger when the condition needing care has been identified during a HEALTH CHECK (EPSDT) screen, the treatment is clinically necessary, the need for this level of care has been identified in the Initial Diagnostic Interview and the client has a serious emotional disturbance as indicated by the following:

1. The youth must have a diagnosable condition under the current Diagnostics and Statistics Manual of the American Psychiatric Association, and that condition is seen as primarily responsible for the client's problems;
2. The condition must result in substantial functional limitations in two or more of the following areas:
  - a. Self-care at an appropriate developmental level;
  - b. Perception and expressive language;
  - c. Learning;
  - d. Self-direction, including behavioral controls, decision-making judgment, and value systems; and
  - e. Capacity for living in a family environment.

32-005.06A Intake Criteria: The following criteria must be met for a client's admission to a treatment foster care program:

1. The need for treatment foster care must be identified on an Initial Diagnostic Interview based on the following criteria:
  - a. The client must have sufficient need for active treatment at the time of intake to justify the expenditure of the client/family's and program's time, energy, and resources;
  - b. Of all reasonable options for active treatment available to the client, active treatment in this program must be the best choice for expecting reasonable improvement in the client's condition;
2. The proposed or revised treatment plan must be the most efficient and appropriate use of the program to meet the client/family's particular needs;
3. The plan must address active and ongoing involvement of the family in care provision; and
4. The program is designed to meet the needs of clients age 20 and younger.

#### 32-005.07 Preadmission Authorization and Continued Stay Review

32-005.07A Preadmission Authorization: For treatment foster care services to be covered by Medicaid, the need for admission to this level of care must be precertified by a licensed practitioner of the healing arts who is able to diagnose and treat major mental illness within his/her scope of practice through an Initial Diagnostic Interview.

32-005.07B Prior Authorization: Treatment Foster Care Services must be prior authorized by the Division of Medicaid and Long-Term Care or its designee.

32-005.07C Continued Stay Review/Utilization Review: Each program is responsible for establishing a utilization review plan and procedure. A site visit by Medicaid and/or Health and Human Services staff for purpose of utilization review may be required for further clarification and review for payment (see 471 NAC 32-001.11).

32-005.08 Documentation

32-005.08A Treatment Plan: The treatment plan must be developed within the first 14 days after the client's admission to the program. The plan must be reviewed by the multi-disciplinary team at least every 30 days thereafter.

The multi-disciplinary treatment team consists of the treatment parent, the TFC specialist, the supervising practitioner, and other persons as necessary (parents, Department case manager).

Copies of the treatment plan must be retained in the client's record.

The treatment plan retained in the client's record must include -

1. The client's name;
2. The client's Medicaid number;
3. An indication if the client is a Department ward;
4. Date of the HEALTH CHECK during which the condition was disclosed;
5. The name of the referring physician (EPSDT);
6. The client's gender;
7. The client's age;
8. An indication if this is an initial or updated document;
9. The date of the initial diagnostic interview;
10. The date of the last report;
11. The date of this report;
12. Current active symptoms and/or functional impairments;
13. Date of onset of current acute condition;
14. An indication of whether this service was court-ordered (a copy of the court order must be attached);
15. An indication of whether psychological testing and/or a substance abuse evaluation has been completed (a copy of the results must be included);
16. Associated medical, legal, social, educational, occupational, or other problems;
17. Consultations;
18. Diagnoses;
19. Progress or complications since last report, including the client/family's participation in treatment;
20. Short term goals;

21. Long term goals;
22. Therapeutic interventions prescribed by the treatment team (frequency and by whom) including:
  - a. Family therapy, training, and visits;
  - b. Behavioral management;
  - c. Individual counseling; and
  - d. Group counseling;
23. Medication prescribed, physician monitoring medication, frequency, and dose;
24. The estimated length of stay at this level of care;
25. Placement and discharge plan;
26. Prognosis and brief explanation;
27. The provider's name; and
28. The provider's Medicaid number.

The treatment plan must be signed by the supervising practitioner.

32-005.08B Documentation in the Client's Clinical Record: Each client/family's clinical record must contain the following information:

1. The treatment plan;
2. The team progress notes, recorded chronologically. The frequency is determined by the client's condition, but the progress notes must be recorded at least daily. The progress notes must contain a concise assessment of the client/family's progress and recommendations for revising the treatment plan, as indicated by the client/family's condition, and discharge planning;
3. The program's utilization review committee's abstract or summary;
4. The discharge summary; and
5. Other documentation as required in 471 NAC 32-001.05.

32-005.09 Procedure Codes and Descriptions for Treatment Foster Care: HCPCS/CPT procedure codes used by NMAP are listed in the Nebraska Medicaid Practitioner Fee Schedule at 471-000-532.

32-005.10 Costs Not Included in the Treatment Foster Care Per Diem: The mandatory, family therapy and optional services are considered to be part of the per diem for TFC. The following charges can be reimbursed separately from the TFC per diem when the services are necessary, part of the client's overall treatment plan, and in compliance with NMAP policy:

1. Direct client services performed by the supervising practitioner;
2. Prescription medications (including injectable medications);
3. Direct client services performed by a physician or psychologist other than the supervising practitioner;
4. Treatment services for a physical injury or illness provided by other professionals; and
5. Other necessary treatment interventions including individual or group therapy and day treatment services.



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

The TFC per diem does not include room and board costs.

32-005.11 Services Not Covered: Payment is not available for treatment foster care for clients

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

32-005.12 Inspections of Care: The Department's inspection of care team may conduct inspection of care reviews for Treatment Foster Care Services. Please refer to 471 NAC 32-001.08 and 32-001.09.

### 32-006 Treatment Group Home

32-006.01 Introduction and Legal Basis: Treatment group home services are available to clients age 20 or younger when the client has participated in a HEALTH CHECK (EPSDT) screen, the treatment is clinically necessary, and the need for this level of care has been identified as part of an Initial Diagnostic Interview. Treatment group homes are non-hospital based treatment services that are community-based, family-centered, and culturally competent.

Treatment group home services for children and adolescents covered by Medicaid include treatment group home services for children age 20 and younger who are eligible for Medicaid. The policy in this section also covers children age 18 or younger who are wards of the Department.

Treatment group home services must be recommended by a licensed practitioner of the healing arts who is able to diagnose and treat major mental illness within his/her scope of practice for reduction of physical or mental disability, to restore a recipient to a better level of functioning, and to facilitate discharge to a less restrictive level of care.

32-006.02 Treatment Group Home Services for Children: The Department's philosophy is that all care provided to clients must be provided at the least restrictive and most appropriate level of care. Care must be developmentally appropriate, family-centered, culturally competent and community based. It must directly involve the immediate family in all phases of treatment and discharge planning. Family may include biological, step, foster, or adoptive parents, sibling or half sibling, and extended family members as appropriate.

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

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

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

Care must involve a representative from the appropriate home community service providers. This may include such areas as education, social services, law enforcement, religion, medical, and mental health professionals. NMAP will cover more restrictive levels of care only when all other resources have been explored and deemed to be inappropriate. If hospital-based inpatient care is deemed appropriate, see 471 NAC 32-008. If psychiatric residential treatment services are deemed appropriate, see 471 NAC 32-007.

To ensure a less institutional setting, each location where children are housed can serve no more than 2 units of up to 20 beds . Facilities may have up to two crisis intervention beds per unit (see 32-003 Treatment Crisis Intervention) and the facility must provide a home-like atmosphere.

### 32-006.03 Standards for Participation for Treatment Group Home Services

32-006.03A Provider Agreement: A provider of treatment group home services shall complete Form MC-19 or MC-20, "Medical Assistance Provider Agreement," and submit the completed form to the Department for approval. The Department is the sole determiner of which facilities are approved for participation in this program. The facility will be advised in writing when its participation is approved.

The provider shall submit the following with Form MC-19 or MC-20:

1. A written overview of the program's philosophy and objectives of treating children and youth including:
  - a. A complete description of how the family-centered requirement will be met, including a complete description of any home-based family therapy services;
  - b. A complete description of how the community-based requirement will be met;
  - c. A description of each available service;
  - d. A list of treatment modalities available and the capacity for individualized treatment planning;
  - e. A statement of the qualification, education, and experience of each staff member providing treatment and the therapy service each provides;
  - f. A schedule covering the total number of hours that the program operates;
  - g. The Department approved cost reporting document; and
  - h. The target population.
2. Facility/Program Changes: A treatment group home facility shall report to the HHS Resource Development and Support Unit and to the Division of Medicaid and Long-Term Care any major change in its program and/or facilities, before the change is made. The HHS Resource Development and Support Unit will determine whether the license must be modified or reissued. Any change in the capacity of a licensed facility requires that a license be reissued showing the number of youth who can be cared for under the new plan. The Division of Medicaid and Long-Term Care will determine if the facility maintains appropriate therapeutic programming for NMAP reimbursement.

3. Confirmation that the staffing standards in 471 NAC 32-006.03E are met.
4. Current licensure as a child caring agency. If the child caring agency license is denied or revoked, this requirement is not met; therefore, the provider is not eligible for participation.

32-006.03B Place of Service: Treatment group home services may be provided in the following locations when the requirements in this section have been met:

1. A community-based facility in operation prior to 7-1-94, as a treatment group facility. (These facilities may apply for an exception to the unit/bed maximum. The Department is the sole determiner of eligibility for this exception.)
2. A residential type community-based treatment facility appropriately licensed by the Nebraska Department of Health and Human Services, Division of Public Health; or
3. A hospital that is licensed as a hospital by the Nebraska Department of Health and Human Services, Division of Public Health, is accredited by the Joint Commission on Accreditation of Health-Care Organizations (JCAHO) or the American Osteopathic Association (AOA), meets the requirements for participation in Medicare, and has a utilization review plan applicable to all Medicaid clients in effect.

32-006.03B1 Facility and Program Requirements: In order to be approved as a provider of Treatment Group Home Services, the program must insure that the following requirements are met:

1. Adequate access to recreational facilities for both indoor and outdoor activities, commensurate with the size and scope of the program. (This may be provided on-site or through contract);
2. Separation of the treatment group home program from inpatient hospital operations, including laboratory, radiology, surgery, patient rooms, dining areas, patient lounges, etc.;
3. The doors to the unit and to the outside may be locked from the outside to allow for safety, but they must be unlocked or easily unlocked from the inside;
4. Kitchen and laundry facilities easily accessible to the unit;
5. Staff offices must be located on the unit;
6. Secure storage for medications and clinical charts must be on the unit;
7. A general living or lounge area must be on the unit;
8. A home-like atmosphere;
9. Program is staffed by awake personnel 24 hours per day; and
10. Other requirements as listed in this chapter.

32-006.03C Licensure: The treatment group home facility must -

1. Be in compliance with all applicable federal, state, and local laws;
2. Meet the program and operational definitions and criteria contained in the Nebraska Department of Health and Human Services Manual;
3. Meet the definition of a treatment group home facility as stated in this section;
4. Maintain documentation in each client's treatment record that provides a full and complete picture of the nature and quality of all services provided (see 471 NAC 32-006.07);
5. Have the capacity to meet the needs of the individual Medicaid client either through employment of or contracts with appropriate staff;
6. Be licensed under the minimum regulations for child caring agencies if not a hospital-based facility. If the child caring agency license is denied or revoked, this requirement is not met; therefore, the provider is not eligible for participation. (See 474 NAC 6-005, Licensing Group Homes and Child Caring and Placing Agencies.)

32-006.03D Accreditation: The licensed treatment group home must have -

1. Be accredited by JCAHO, CARF, COA or AOA; or
2. Include a copy of the accreditation certificate with the initial and updated enrollment materials and forward a copy of all survey visit reports and provider responses.

Facilities accredited by these accrediting bodies are eligible to receive reimbursement for treatment and maintenance (room and board) costs and must maintain accreditation in order to qualify as a treatment group home provider. Treatment and maintenance costs are reimbursed as a per diem rate. See NMAP Fee Schedule, (Appendix 471-000-532).

Interpretive Note: Agencies that have applied for accreditation may be enrolled on a provisional status and receive reimbursement for treatment services only.

32-006.03E Staffing Standards for Participation: A treatment group home for children shall meet the following standards to participate in NMAP:

1. The facility's staff must include -
  - a. An executive director who has sufficient background and experience to administer a treatment program;
  - b. A program director who meets the requirements of a clinical staff person in 471 NAC 32-001.04 and is acting within his/her scope of practice, with two years of professional experience in the treatment of children and adolescents with mental illnesses or emotional disturbances;
  - c. Clinical staff professionals (who meet the requirements of a clinical staff person in 471 NAC 32-001.04) who provide family assessments and psychotherapy, including face-to-face individual, family, and group therapy, who are supervised by a licensed practitioner of the healing arts who is able to diagnose and treat major mental illness within his/her scope of practice;
  - d. Child care staff who are age 21 or older and have specialized training and experience sufficient to equip them for their duties and are under the supervision of the program director. 67% of child care staff must have a bachelor's degree or four years of experience in the human services field;
  - e. Supervisory staff will meet the standards outlined in 471 NAC 32-001.04 and have four years experience in a related field;
  - f. Training must be approved by the Department and must meet the minimum standards for pre-service and on-going training in licensing requirements;
  - g. A supervising practitioner who is a licensed practitioner of the healing arts who is able to diagnose and treat major mental illness within his/her scope of practice;
  - h. Each facility shall show by employment records or on a contractual basis the ability to provide the needed services as indicated by the scope of the program, including necessary medical/psychiatric evaluations, and access to emergency care. The clinical services of a psychologist, psychiatrist, and physician may be obtained on a consultation basis; and
  - i. Educators, when on-site education is provided. Services must be provided in accordance with applicable state and federal laws. NMAP does not make payment for educational services (see 471 NAC 32-006.05J);
2. Volunteer services may be used to augment and assist other staff in carrying out program or treatment plans. Volunteers who work directly with youth must receive orientation training regarding the program, staff, and children of the center and the functions that volunteers can perform. However, the services performed by a volunteer cannot be substituted for necessary medical/psychiatric and therapeutic patient/staff ratios;

3. Staff must be mentally and physically capable of performing assigned duties and demonstrate basic professional competencies as required by the job description. Every staff member shall have an annual physical examination and obtain a statement that no medical condition exists that may interfere with his/her ability to perform assigned duties. This is addressed in policy governing licensure regulations. All applicable state, federal, and local laws must be followed;
4. All program personnel having access to clients, including full-time, part-time, paid, volunteer, or contract, must be checked through the Central Registry, Adult Protective Services Registry, and the motor vehicle records. A criminal check must also be done through a law enforcement agency. A person whose name appears on any of the above registers because of behavior or activities that might be dangerous to clients must not have access to clients;
5. The ratio of professional staff to children is dependent on the needs of the children and commensurate with the size and scope of the program, however -
  - a. The minimum ratio of Master's level therapists providing direct face-to-face therapy services to children and families must be 1:12;
  - b. The supervising practitioner must be available to spend approximately 45 minutes per month or more often as clinically necessary, per client, in the facility as a minimum. This includes face-to-face time with the client, treatment plan reviews, and supervision;
  - c. There must be sufficient supervising practitioner consultation hours on a regular basis to meet the requirements for active treatment. Youth at this level of care must be assessed by the supervising practitioner a minimum of once a month, or more frequently if medically necessary;
6. The ratio of child care staff to children during prime time hours is dependent on the needs of the children and the requirements of the individualized treatment plans. The ratio of staff to children must be commensurate with the size and scope of the program; however, minimum ratio is 1:6. This may be increased depending on the intensity of the program and the children's needs;
7. The ratio of child care awake staff during sleeping and non-prime hours is dependent on the needs of the children and must be commensurate with the size and scope of the program; however, the minimum ratio is 1:8. This may be increased depending on the intensity of the program and the individual child's needs.
8. The facility must be able to call back child care staff to provide staff and client safety in crisis situations.
9. If the facility has a level program that requires intense observation for admissions, the direct care staff to youth ratio will need to be more intense during that observation period.
10. Access to emergency services such as additional supervision and physician psychologist services must be available on a 24-hour basis.

32-006.03F Service Standards for Participation for Treatment Group Home Facilities:  
Treatment group home facilities shall -

1. Make every effort to keep the child in contact, where appropriate and possible, with the child's family and relatives, when reunification/reconciliation is the plan and maintain documentation of these activities;
2. Directly involve the immediate family in all phases of treatment and discharge planning. Family may include biological, step, foster, or adoptive parents, sibling or half sibling, and extended family members as appropriate. For wards of the Department, the case manager must be included in all phases of assessment, treatment planning, evaluation of services, and discharge/after care arrangements;
3. Provide a total of 21 hours of scheduled treatment interventions each week. These must include, but are not limited to:
  - a. Group psychotherapy by a practitioner operating within their scope of practice;
  - b. Individual therapy by a practitioner operating within their scope of practice;
  - c. Family intervention (one hour per week minimum); and
  - d. Other approved group or individual therapeutic activities.
4. Provide or arrange for face-to-face family therapy a minimum of twice a month. Depending on the child's needs, this may include reunification/reconciliation therapy and may also include biological, step, foster or adoptive families, psychological parents, and/or extended family (this is included in the 21 hours per week);
5. Provide the following mandatory services -
  - a. Clinically Necessary Nursing Services: Medical services directed by a Qualified Registered Nurse who evaluates the particular medical nursing needs of each client and provides for the medical care and treatment that is indicated on the Department approved treatment planning document approved by the supervising practitioner.
  - b. Clinically Necessary Psychological Diagnostic Services: Testing and evaluation services must reasonably be expected to contribute to the diagnosis and plan of care established for the individual client. Testing and evaluation services may be performed by a licensed psychologist acting within his/her scope of practice. Clinical necessity must be documented by the program supervising practitioner. Reimbursement for psychological diagnostic services is included in the per diem.
  - c. Clinically Necessary Pharmaceutical Services: If medications are dispensed by the program, pharmacy services must be provided under the supervision of a registered pharmacy consultant; or the program may contract for these services through an outside licensed/certified facility. All medications must be stored in a special locked storage space and administered only by a physician, registered nurse, licensed practical nurse, or by a staff person approved by the Nebraska Department of Health and Human Services, Division of Public Health as a Medication Aide.



- d. Clinically Necessary Dietary Services: The meal services provided must be supervised by a registered dietitian, based on the client's individualized diet needs. Programs may contract for these services through an outside licensed certified facility.
  - e. Transition and discharge planning must meet the requirements of 471 NAC 32-001.07A.
6. Optional Services: The program must provide two of the following optional services. The client must have a need for the services, the supervising practitioner must order the services, and the services must be a part of the client's treatment plan. The therapies must be restorative in nature, not prescribed for conditions that have plateaued or cannot be significantly improved by the therapy, or which would be considered maintenance therapy:
- a. Services provided or supervised by a licensed or certified therapist may be provided under the supervision of a qualified consultant or the program may contract for these services from a licensed/certified professional as listed below:
    - (1) Recreational Therapy;
    - (2) Speech Therapy;
    - (3) Occupational Therapy;
    - (4) Vocational Skills Therapy;
    - (5) Self-Care Services: Services supervised by a staff person who is oriented toward activities of daily living and personal hygiene. This includes toileting, bathing, grooming, etc.
  - b. Psychoeducational Services: 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 adolescent experiencing mental health or substance abuse 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.
  - c. Social Work Services by a Bachelor's Level Social Worker: Case management social services to assist with personal, family, and adjustment problems which may interfere with effective use of treatment;
  - d. Crisis Intervention (may be provided in the client's home);
  - e. Social Skills Building;
  - f. Life Survival Skills;
  - g. Substance abuse prevention, intervention, or treatment by an appropriately licensed alcohol and drug counselor.

7. Provide appropriate conferences involving the client's interdisciplinary treatment team, the parents, the referring agency, and the child, to review the case status and progress at least every month. This does not substitute for documentation requirements. The need for conferences with interested parties is indicated by the individual child's circumstances and needs. For wards of the Department, this need will be jointly determined with the Department case manager;
8. Provide a multi-disciplinary team progress report to the referring agency, the parents, and the legal guardian every month for the purpose of service coordination. This progress report must include a summary of the work done, the progress made by each multi-disciplinary team area, since the last report; plus treatment plans for the next reporting period. For wards of the Department, monthly reports must be provided to the Division of Children and Family Services case manager. The documentation from the Monthly Treatment Plan review may serve this purpose.
9. The services of specialists in the fields of medicine, psychiatry, clinical psychology, and education must be used as needed. The costs of these services must be included in the total cost of care and cannot be billed separately.
10. Allow for more than one type of activity to be scheduled at one time allowing for specialized and individualized treatment planning.

32-006.03G Annual Update Renewal: The treatment group home shall submit the following information with the provider application and agreement, and update/renew the information annually to coincide with submission of the cost report:

1. A written overview of the program's philosophy and objectives of treating children and youth including:
  - a. A complete description of how the family-centered requirement will be met, including a complete description of any home-based family therapy services;
  - b. A complete description of how the community-based requirement will be met;
  - c. A description of each available service;
  - d. A list of treatment modalities available and the capacity for individualized treatment planning;
  - e. A statement of the qualification, education, and experience of each staff member providing treatment and the therapy service each provides;
  - f. A schedule covering the total number of hours that the program operates;
  - g. The cost report; and
  - h. The target population.
2. Confirmation that the staffing standards are met;
3. A copy of child caring agency licensure certificate; and
4. A copy of accreditation from JCAHO, CARF, COA, or AOA.

The Division of Medicaid and Long-Term Care or its designee may request this information on an intermittent basis and the provider must comply by promptly supplying the requested information.

32-006.04 Covered Services: Medicaid limits payment for treatment group home services to those services for medically necessary primary psychiatric diagnoses. Medicaid covers treatment group home services when the services are medically necessary and provide active treatment.

32-006.04A Pre-Admission Authorization: For treatment group home services to be covered by Medicaid, the admission must be recommended by a licensed practitioner of the healing arts who is able to diagnose and treat major mental illness within their scope of practice through an Initial Diagnostic Interview and prior authorized through the Division of Medicaid and Long-Term Care or its designee. Consent for treatment for wards of the Department must be obtained from the case manager or supervisor.

32-006.04B Guidelines for Use of the Treatment Group Home Services for Children: A youth must have a diagnostic condition listed in the current diagnostic and statistics manual of the American Psychiatric Association (excluding V-codes and developmental disorders) for this level of care. NMAP applies the following general guidelines to determine when treatment group home services for children are clinically necessary for a client:

1. The child/youth requires 24-hour awake supervision;
2. Utilization of treatment group home care is appropriate for individualized treatment and is expected to improve the client's condition to facilitate moving the client to a less restrictive placement;
3. The child/youth's problem behaviors are persistent, may be unpredictable, and may jeopardize the health or safety of the client and/or others, but can be managed with this moderate level of structure;
4. The child/youth's daily functioning is moderately impaired in such areas as family relationships, education, daily living skills, community, health, etc.;
5. The child/youth has a history of previous problems due to ongoing inappropriate behaviors or psychiatric symptoms; or
6. Less restrictive treatment approaches have not been successful (see 42 CFR 441.152) or are deemed inappropriate by the supervising practitioner or treatment in a more restrictive setting has helped stabilize the client's behavior or psychiatric symptoms and they are ready to transition to a less restrictive level of care.

32-006.04C Therapeutic Passes for Clients Involved in Treatment Group Home Services: Therapeutic passes are an essential part of the treatment for client/families involved in treatment group home services. Documentation of the client's continued need for treatment group home services must follow overnight therapeutic passes. Therapeutic passes must be indicated in the treatment plan as they become appropriate. NMAP reimburses for only 60 therapeutic pass days per client per year. This includes all treatment services in which the client is involved during the year.

Therapeutic leave days are counted by the entity reimbursing for the care. Because the NMAP fee-for-service program reimburses for therapeutic leave days on a post-service basis and because providers have one year to bill for services, the Department cannot guarantee that an accurate account of the therapeutic leave days that have been used.

32-006.04D Vacations: If a treatment group home program takes the clients on a "vacation," NMAP will reimburse for those days under the following conditions -

1. The trip is prior authorized by the Division of Medicaid and Long-Term Care or its designee;
2. There is a clear statement of goals and objectives for the client's participation in the trip;
3. At least 50% of the scheduled treatment interventions must occur during the "vacation";
4. A clinical staff person must accompany the "vacation" trip; and
5. The "vacation" must be included in the treatment program.

NMAP will reimburse for up to seven "vacation" days per year for clients in treatment group home services.

#### 32-006.05 Additional Requirements

32-006.05A Work Experience: When a treatment group home has a work program, it must -

1. Provide work experience that is appropriate to the developmental age and abilities of the child;
2. Differentiate between the chores that children are expected to perform as their share in the process of living together, specific work assignments available to children as a means of earning money, and jobs performed in or out of the center to gain vocational training;
3. Give children some choice in their work experiences and offer change from routine duties to provide a variety of experiences;
4. Not interfere with the child's time for school, study periods, play, chores, sleep, normal community activities, visits with the child's family, or individual, group, or family therapy;  
Clients may not be solely responsible for any major phase of the center's operation or maintenance, such as cooking, laundering, housekeeping, farming, or repairing;
5. Comply with all state and federal labor laws.

32-006.05B Solicitation of Funds: A treatment group home may not use a child for advertising, soliciting funds, or in any way that may cause harm or embarrassment to the child or the child's family. Written consent of the parent or guardian must be obtained before the treatment group home uses a child's picture, person, or name in any form of written, visual, or verbal communication. Before obtaining consent, the treatment group home shall advise the parent or guardian of the purpose for which it intends to use the child's picture, person, or name, and of the times and places when and where this use would occur. Photos of the Department state wards cannot be used for these purposes.

32-006.05C Special Treatment Procedures: Special treatment procedures in treatment group homes are limited to physical restraint. Locked time out (LTO), mechanical restraints, and pressure point tactics are not allowed. For wards of the Department, the case manager must approve use of physical restraints and must be informed within 24 hours each time they are used. Guardians and parents of non-wards must give informed consent and be informed of the use of physical restraints.

Facilities must meet the following standards regarding physical restraints:

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

These standards must be reflected in all aspects of the treatment program. Attempts to de-escalate, the use of restraints, and subsequent processing must be documented in the clinical record.

32-006.05D Medical Care: The center shall ensure that the following medical care is provided for each child:

1. Each child must receive a medical examination immediately before or at the time of admission;
2. Each child must have current immunizations as required by the Nebraska Department of Health and Human Services;
3. The treatment group home shall arrange with a physician and a psychiatrist for the medical and psychiatric care of the clients;
4. Each child must have a medical examination/HEALTH CHECK (EPSDT) screen annually as allowed in 471 NAC 33-000 ff.;
5. The treatment group home shall inform staff members of what medical care, including first aid, may be given by staff without specific physician orders. Staff must be instructed on how to obtain further medical care and how to handle emergency cases. The center shall ensure that -
  - a. Staff members on duty must have satisfactorily completed current first aid and cardiopulmonary resuscitation training and have on file at the treatment group home a certificate of satisfactory completion as required by licensure regulations of the Department of Health and Human Services, Division of Public Health;
  - b. Each staff member must be able to recognize the common symptoms of illnesses in children and to note any marked physical defects of children; and
  - c. A sterile clinical thermometer, a complete first aid kit, and clearly posted emergency phone numbers must be available, according to licensure regulations of the Department of Health and Human Services.

32-006.05E Hospital Admissions: The treatment group home shall make arrangements for the emergency admission of children from the center in case of serious illness, emergency, or psychiatric crisis. For wards of the Department, the case manager or the case manager's supervisor must give permission for admission.

In the event that a client does require hospitalization while in a treatment group home, NMAP will reimburse the treatment program for up to 15 days per hospitalization. This reimbursement is only available if the treatment placement is not used by another client.

32-006.05F Hospitalization or Death Reports: The treatment group home shall report any accident or illness requiring hospitalization to the parents or guardian immediately. The treatment group home shall immediately report any death to the parents or guardian, the Department, a law enforcement agency, and the county coroner. If the child is a Department ward, see 390 NAC 11-002.01D.

32-006.05G Dental Care: Each child must have an annual dental examination. If a child has not had a dental exam in the twelve months before admission, an examination must occur within 90 days following admission. See 471 NAC 6-000 and 33-000 and 474 NAC 6-005.26F.

32-006.05H General Health: The treatment group home shall ensure the following:

1. Each child must have enough sleep for the child's age and physical and emotional condition at regular and reasonable hours, and under conditions conducive to rest. While children are asleep, at least one staff member must be within hearing distance;
2. Children must be encouraged and helped to keep themselves clean;
3. Bathing and toilet facilities must be properly maintained and kept clean;
4. Each child must have a toothbrush, comb, an adequate supply of towels and washcloths, and personal toilet articles;
5. Menus must provide for a varied diet that meets a child's daily nutritional requirements;
6. Each child must have clothing for the child's exclusive use. The clothing must be comfortable and appropriate for the current weather conditions; and
7. The treatment group home must provide safe, age-appropriate equipment for indoor and outdoor play.

See 471 NAC 33-000.

32-006.05J Education: Educational services, when required by law, must be available. Education services must only be one aspect of the treatment plan, not the primary reason for admission or treatment. Educational services are not eligible for payment by the Department.

32-006.05K Religious Education: Children must be provided with an opportunity to receive instruction in their religion. No child may be required to attend religious services or to receive religious instructions if the child chooses not to attend the services or receive instruction.

32-006.05L Discipline: Discipline must be therapeutic and remedial rather than punitive. Corporal punishment, verbal abuse, and derogatory remarks about the child, the child's family, religion, or cultural background are prohibited. A child may not be slapped, punched, spanked, shaken, pinched, or struck with an object by any staff of the center. Only staff members of the treatment group home may discipline children (see 474 NAC 6-005.26K).

32-006.05M Transition and Discharge Planning: Whenever a child or adolescent is transferred from one setting to another, transition and discharge planning must be performed and be documented, beginning at the time of admission (see 471 NAC 32-001.07A and 474 NAC 6-005.27H).

Facilities must meet the following standards regarding transition and discharge planning:

1. Transition and discharge planning must be based on the multidisciplinary treatment plan designed to achieve the client's transition into and discharge from treatment group home treatment status to a less restrictive level of care at the earliest possible time;
2. Transition and discharge planning must address the client's need for ongoing treatment to maintain treatment gains, continuing education and support for normal physical and mental development following discharge;
3. Discharge planning must include identification of and clear transition into developmentally appropriate services needed following discharge;
4. The treatment group home treatment facility shall arrange for prompt transfer of appropriate records and information to ensure continuity of care during transition into and following the client's discharge;
5. A written transition and discharge summary must be provided as part of the medical record; and
6. The child's parents (and the caseworker if the child is a ward) must be included in all phases of transition and discharge planning. This participation must be clearly documented in the client's record.



32-006.05N Notification of Runaway Children: See 390 NAC 7-001.05.

32-006.05P Interstate Compact on the Placement of Children: The center shall comply with the interstate compact on the placement of children. (See 474 NAC 6-005.)

32-006.05Q Medications: The treatment group home may possess a limited quantity of nonprescription medications and administer them under the supervision of designated staff. The treatment group home must follow all applicable regulations through the Department of Health and Human Services, Division of Public Health for storing and administering medications.

The treatment group home shall have written policies governing the use of psychotropic medications. Parents and the guardian of a client who receives psychotropic medication must be informed of the benefits, risks, side effects, and potential effects of medications. A parent and legal guardian's written informed consent for use of the medication must be obtained before giving the medication and filed in the client's record. If the client is a state ward, informed consent must be given by the Department case manager.

A child's medication regime must be reviewed by the prescribing physician at least every seven days for the first 30 days following the initiation of a new medication and at least every 30 days thereafter.

32-006.06 Individualized Treatment: The requirements of 42 CFR 441, Subpart D, must be met. To be covered by NMAP, services must include -

1. Program philosophy: Treatment Group Home facilities must provide family-centered, community-based, developmentally appropriate services under the direction of a supervising practitioner.
  - a. These services must be able to meet the special needs of families with emotionally disturbed children. Families must be involved in all phases of treatment and discharge planning. For wards of the Department, the Department case manager must also be involved in all phases of treatment and discharge planning.
  - b. The program intensity must be such that direct care staff, the youth in treatment, and/or the youth's family have access to professional staff on an "as needed" basis, determined by the child's condition.

2. Active treatment, which must be -
  - a. Treatment provided under a multi-disciplinary treatment plan reviewed and approved by the supervising practitioner. This plan will be developed by a multi-disciplinary team of professional staff members. The treatment plan must be for a primary psychiatric diagnosis and must be based on a thorough evaluation of the client's restorative needs and the client's potential. The initial treatment plan must be developed within 14 days of the client's admission. The treatment plan must be reviewed at least every 30 days by the multi-disciplinary team, the parents and/or the parents' advocate, the referring agency and the child.  
The goals and objectives documented on the treatment plan must reflect the recommendations from the Initial Diagnostic Interview, the supervising practitioner and the therapist. The treatment interventions provided must reflect these recommendations, goals, and objectives. Evaluation of the treatment plan by the therapist and the supervising practitioner should reflect the client's response to the treatment interventions based on the recommendations, goals and objectives.
  - b. In compliance with 471 NAC 32-001.07, Treatment Planning; and
  - c. In compliance with 471 NAC 32-001.06, Active Treatment.
3. Medically necessary services, which must be an appropriate level of care based on the documented Initial Diagnostic Interview by the supervising practitioner either prior to admission or immediately following admission.

32-006.07 Documentation in the Client's Clinical Record: The treatment group home must maintain accurate records indicating the degree and intensity of the treatment provided to clients who receive services in the treatment group home facility. For treatment group home services, clinical records must stress the clinical components of the care, including history of findings and treatment provided for the condition for which the client is in the facility. The record must include the requirements stated in 471 NAC 32-001.05, and -

1. The identification data, including the client's legal status (i.e., voluntary admission, Board of Mental Health commitment, court mandated);
2. A provisional or admitting diagnosis which is determined for every patient at the time of admission and includes the diagnoses of intercurrent diseases as well as the diagnoses;
3. The statements of others regarding the client's problems and needs, as well as the client's statement of their problems and needs;
4. The medical/psychiatric history, which contains a record of the initial diagnostic interview and notes the onset of illness, the circumstances leading to admission, attitudes, behavior, estimate of intellectual functioning, memory functioning, orientation, and an inventory of the client's strengths in a descriptive, not interpretative, fashion;
5. Complete psychological evaluation when indicated;
6. Complete neurological examination, when indicated;

7. A social history sufficient to provide data on the client's relevant past history, present situation, social support system, community resource contacts, and other information relevant to good treatment, and transition and discharge planning;
8. A thorough family assessment;
9. Reports of consultations, electroencephalograms, dental records, and special studies;
10. The treatment received by the client, which is documented in a manner and with a frequency to ensure that all active therapeutic efforts, such as individual, group, and family psychotherapy, drug therapy, milieu therapy, occupational therapy, recreational therapy, nursing care, and other therapeutic interventions, are included;
11. Progress notes must be recorded by all professional staff and, when appropriate, others significantly involved in active treatment modalities, following each contact. The frequency is determined by the individual treatment plan and the condition of the client. Progress notes must contain a concise assessment of the client's progress and recommendations for revising the treatment plan as indicated by the client's condition. Child care workers must maintain 24-hour documentation of a client's whereabouts and activities.
12. The transition plan and discharge summary, including a summary of the client's and family's treatment, recommendations for appropriate services concerning follow-up, and a brief summary of the client's condition on discharge.
13. The psychiatric diagnosis contained in the final diagnosis written in the terminology of the American Psychiatric Association's Diagnostic and Statistical Manual; and
14. The client's response to therapeutic leave days recommended by the supervising practitioner under the treatment plan. The client's, family's, or guardian's response to time spent outside the facility must be entered in the client's clinical record.

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

32-006.08 Utilization Review: All facilities must provide utilization review.

32-006.09 Documentation for Claims: The following documentation is required for all claims for treatment group home services. This requirement may be waived at the Department's discretion. The facility will be notified in writing if that occurs:

1. Initial Diagnostic Interview;
2. The treatment plan;
3. Orders by the supervising practitioner; and
4. Progress notes for all disciplines.

All claims are subject to utilization review by the Department prior to payment.

32-006.09A Exception: Additional documentation from the client's clinical record may be requested by the Department prior to considering authorization of payment.

32-006.10 Procedure Code and Description for Treatment Group Home Services: HCPCS/CPT codes used by NMAP are listed in the Nebraska Medicaid Practitioner Fee Schedule at 471-000-532.

32-006.11 Costs Not Included in the Treatment Group Home Per Diem: The mandatory and optional services are considered to be part of the per diem for treatment services. The following charges can be reimbursed separately from the treatment group home per diem when the services are necessary, part of the client's overall treatment plan, and in compliance with NMAP policy:

1. Direct client services performed by the supervising practitioner;
2. Prescription medications (including injectable medications);
3. Direct client services performed by a physician other than the supervising practitioner; and
4. Treatment services for a physical injury or illness provided by other professionals.

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

32-006.12 Inspections of Care: The Department's inspection of care team may conduct inspection of care reviews for Treatment Group Home Services. See 471 NAC 32-001.08 and 471 NAC 32-001.09.

### 32-007 Residential Treatment Services for Children/Adolescents

32-007.01 Introduction: Residential treatment services are available to clients age 20 or younger when the client participates in a HEALTH CHECK (EPSDT) screen, the treatment is clinically necessary, and the need for care at this level has been identified on the Initial Diagnostic Interview.

Residential treatment services must be family-centered, culturally competent, community based, and developmentally appropriate.

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

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

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

Residential treatment services for children covered by Medicaid include residential treatment for children age 20 and younger who are eligible for Medicaid. These regulations also cover children age 18 or younger who are wards of the Department.

Residential treatment services must be provided under the direction of a supervising practitioner as designated in 471 NAC 32-001.06

32-007.02 Residential Treatment for Children: The Department's philosophy is that all care provided to clients must be provided at the least restrictive and most appropriate level of care. Care must be family-centered, community-based, culturally competent, and developmentally appropriate. Medicaid will cover more restrictive levels of care only when all other resources have been explored and deemed to be inappropriate. If hospital-based inpatient care is deemed appropriate, see 471 NAC 32-008.

Residential treatment center services are clinically necessary services provided to a client who requires professional care and highly structured 24-hour awake care at a greater intensity than that available at the treatment group home and foster home levels.

In keeping with the philosophy that children are better served in more family-like settings, the total number of approved beds for a residential treatment center will not exceed two units of up to 20 beds each, and the center must provide a home-like atmosphere commensurate with the size and scope of the program. Exception: A state owned and operated residential treatment center may exceed two units provided that each unit has no more than 20 beds each. When a state owned and operated residential treatment center exceeds two 20 bed units, children may be placed there for treatment only if all other in state residential treatment center providers have declined to serve the child within a reasonable period of time. This exception shall expire two years after the effective date of the exception.

### 32-007.03 Standards for Participation for Residential Treatment Centers

32-007.03A Provider Agreement: A provider of residential treatment center services shall complete Form MC-19 or Form MC-20, "Medical Assistance Provider Agreement," and submit the completed form to the Department for approval. The Department is the sole determiner of which centers are approved for participation in this program. The facility will be advised in writing when its participation is approved.

The provider shall submit the following with Form MC-19 or Form MC-20:

1. A written overview of the program's philosophy and objectives of treating children and youth including:
  - a. A description of each available service;
  - b. A list of treatment modalities available and the capacity for individualized treatment planning;
  - c. A statement of the qualification, education, and experience of each staff member providing treatment and the therapy service each provides;
  - d. A schedule covering the total number of hours that the program operates;
  - e. The Department approved cost reporting document; and
  - f. The target population.
2. Facility/Program Changes: A residential treatment facility shall report to the HHS Licensing Unit and to the Division of Medicaid and Long-Term Care any major changes in its program and/or facilities, before the change is made. The HHS Licensing Unit will determine whether the license must be modified or reissued. Any change in the capacity of a licensed facility requires that a license be reissued showing the number of youth who can be cared for under the new plan. The Division of Medicaid and Long-Term Care will determine if the facility maintains appropriate therapeutic programming for NMAP.
3. Confirmation that the staffing standards in 471 NAC 32-007.04D are met.
4. Current licensure as a child caring agency. If the child caring agency license is denied or revoked, this requirement is not met; therefore, the provider is not eligible for participation. Licensure as a child caring agency is not required for hospital-based services.
5. Copy of JCAHO, CARF, AOA, or COA accreditation certificate.

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3. Confirmation that the staffing standards in 471 NAC 32-007.04D are met.
4. Current licensure as a child caring agency. If the child caring agency license is denied or revoked, this requirement is not met; therefore, the provider is not eligible for participation. Licensure as a child caring agency is not required for hospital-based services.
5. Copy of JCAHO, CARF, AOA, or COA accreditation certificate.

32-007.03B Place of Service: Residential treatment services may be provided in the following locations when the requirements listed in 471 NAC 32-007.04B have been met:

1. A residential type community-based treatment facility appropriately licensed by the Nebraska Department of Health and Human Services, Division of Public Health; or
2. A hospital that is licensed as a hospital by the Nebraska Department of Health and Human Services, Division of Public Health, is accredited by the Joint Commission on Accreditation of Health-Care Organizations (JCAHO) or the American Osteopathic Association (AOA), meets the requirements for participation in Medicare, and has a utilization review plan applicable to all Medicaid clients in effect.

32-007.03B1 Facility Requirements: In order to be approved as a provider of Residential Treatment Services, the program must insure that the following requirements are met:

1. Adequate access to recreational facilities for both indoor and outdoor activities, commensurate with the size and scope of the program. (This may be provided on-site or through contract);
2. Separation of the treatment group home program from inpatient hospital operations, including laboratory, radiology, surgery, patient rooms, dining areas, patient lounges, etc.;
3. The doors to the unit and to the outside may be locked from the outside to allow for safety, but they must be unlocked or easily unlocked from the inside;
4. Kitchen and laundry facilities easily accessible to the unit;
5. Staff offices must be located on the unit;
6. Secure storage for medications and clinical charts must be on the unit;
7. A general living or lounge area must be on the unit;
8. A home-like atmosphere;
9. Program is staffed by awake personnel 24 hours per day; and
10. Other requirements as listed in this chapter.

32-007.03C Other Requirements: The residential treatment center must -

1. Be in conformance with all applicable federal, state, and local laws;
2. Meet the program and operational definitions and criteria contained in the Nebraska HHS Finance and Support Manual;
3. Meet the definition of a residential treatment center as stated in 471 NAC 32-007.02;



4. Maintain documentation in each client's treatment record that provides a full and complete picture of the nature and quality of all services provided (see 471 NAC 32-007.07);
5. Have the capacity to meet the needs of the individual Medicaid client either through employment of or contracts with appropriate staff (see 471 NAC 32-007.04D);
6. Be licensed by the Department under the minimum regulations for child caring agencies. If the child caring agency license is denied or revoked, this requirement is not met; therefore, the provider is not eligible for participation (See 474 NAC 6-005, Licensing Group Homes and Child Caring and Placing Agencies and Nebraska State Statute 81-505.01, 1983.) Hospitals are not required to be licensed as a child caring agency.

32-007.03D Accreditation: The residential treatment center must have -

1. Be accredited by JCAHO, CARF, COA or AOA; or
2. Include a copy of the accreditation certificate with the initial and updated enrollment materials and forward a copy of all survey visit reports and provider responses.

If the most recent survey required a plan of corrections, the plan must also be submitted; or

Agencies accredited through these accrediting bodies are eligible for NMAP reimbursement of treatment and maintenance (room and board) costs and must maintain accreditation in order to qualify as a residential treatment services provider. Treatment and maintenance costs are reimbursed as a per diem rate. See NMAP Fee Schedule, (Appendix 471-000-532).

Interpretive Note: Agencies that have applied for accreditation with one of these entities may be enrolled on a provisional status and receive reimbursement for treatment only.

32-007.03E Staffing Standards for Participation: A residential treatment center for children shall meet the following standards to participate in NMAP:

1. The center's staff must include -
  - a. An executive director who has a sufficient background and experience to administered a treatment program;
  - b. A program director who meets the requirements of a clinical staff person in 471 NAC 32-001.04 and is operating within his/her scope of practice, with two years of professional experience in the treatment of children and adolescents with mental illnesses or emotional disturbances;
  - c. Clinical staff professionals (who meet the requirements of a clinical staff person in 471 NAC 32-001.04) who provide psychotherapy and counseling, including face-to-face individual, family, and group counseling, who are directed by the supervising practitioner;

- d. Child care staff who are age 21 or older and have specialized training and experience sufficient to equip them for their duties and are under the supervision of the program director. 75% of child care staff must have a bachelor's degree or five years of experience in human services field;
  - e. Supervisory staff will meet the standards outlined in 471 NAC 32-001.04 and four years experience in a related field.
  - f. Training must be approved by the Department and must meet the minimum standards for pre-service and on-going training in licensing requirements;
  - g. A supervising practitioner who is a licensed psychologist, physician, or doctor or osteopathy;
  - h. Each facility shall show by employment records or on a contractual basis the ability to provide the needed services as indicated by the scope of the program, including necessary medical/psychiatric evaluations, and access to emergency care. The clinical services of a psychologist, psychiatrist, and physician may be obtained on a consultation basis; and
  - j. Educators, when on-site education is provided. Services must be provided in accordance with applicable state and federal laws. NMAP does not make payment for educational services;
2. Volunteer services may be used to augment and assist other staff in carrying out program or treatment plans. Volunteers who work directly with youth must receive orientation training regarding the program, staff, and children of the center and the functions that volunteers can perform. However, the services performed by a volunteer cannot be substituted for necessary medical/psychiatric and therapeutic patient/staff ratios;
  3. Staff must be mentally and physically capable of performing assigned duties and demonstrate basic professional competencies as required by the job description. Every staff member shall have an annual physical examination and obtain a statement that no medical condition exists that may interfere with his/her ability to perform assigned duties. This is addressed in policy governing licensure regulations. All applicable state, federal, and local laws must be followed.
  4. All program personnel having access to clients, including full-time, part-time, paid, volunteer or contract, must be checked through the Central Registry, Adult Protective Services Registry, and the motor vehicle records. A criminal check must also be done through a law enforcement agency. A person whose name appears on any of the above registries must not have access to clients.

5. The ratio of professional staff to children is dependent on the needs of the children and commensurate with the size and scope of the program, however -
  - a. The minimum ratio of Master's level therapists providing direct face-to-face therapy services to children and families must be 1:10;
  - b. The supervising practitioner must be available to spend approximately 45 minutes (or more often as clinically necessary) per month, per client, in the facility as a minimum. This includes face-to-face time with the client, treatment plan reviews, and supervision;
  - c. There must be sufficient supervising practitioner consultation hours on a regular basis to meet the requirements for active treatment (see 471 NAC 32-007.06) and to properly supervise the Master's level therapists (see 471 NAC 32-007.03F). Youth at this level of care must be seen and interviewed by the supervising practitioner a minimum of once every 30 days.
6. The ratio of child care staff to children during prime time hours is dependent on the needs of the children and the requirements of the individualized treatment plans. The ratio of staff to children must be commensurate with the size and scope of the program; however, minimum ratio is 1:4. This may be increased depending on the intensity of the program and the child's needs.
7. The ratio of child care awake staff during sleeping and non-prime hours is dependent on the needs of the children and must be commensurate with the size and scope of the program; however, the minimum ratio is 1:6. This may be increased depending on the intensity of the program and the individual child's needs.
8. The facility must be able to call back child care staff to provide staff and client safety in crisis situations.
9. If the facility has a level program that requires intense observation for admissions, the direct care staff to youth ratio will need to be more intense during that observation period.
10. Access to emergency services such as additional supervision and medical/psychiatric care must be available on a 24-hour basis.
11. Those facilities providing this service prior to the effective date of this policy may apply to become an approved provider with their current staffing levels provided:
  - a. Any new staff hired must meet the criteria stated in these policies; and
  - b. Staff ratios are upgraded to policy standards within four months of the policy's effective date.

32-007.03F Service Standards for Participation for Residential Treatment Centers:  
Residential treatment centers shall -

1. Make every effort to keep the child in contact, when appropriate and possible, with the child's family and relatives, when reunification or reconciliation is the plan;
2. Involve the parents and family, when appropriate and possible, in the treatment planning. For wards of the Department, the case manager must be included in all phases of assessment, treatment planning, evaluation of services, and discharge/after care arrangements;
3. Provide a minimum of 42 hours of scheduled treatment intervention per week. These include, but are not limited to:
  - a. Group psychotherapy by a practitioner operating within his/her scope of practice;
  - b. Individual therapy by a practitioner operating within his/her scope of practice;
  - c. Family intervention (one hour per week minimum);
  - d. Face-to-face sessions with the supervising practitioner; and
  - e. Other approved group or individual therapeutic activities.
4. Provide or arrange for face-to-face family therapy a minimum of twice a month. Depending on the child's needs, this may include reunification/reconciliation therapy and may also include biological families, foster families, adoptive families, and/or extended family;
5. Provide the following mandatory services -
  - a. Clinically Necessary Nursing Services: Medical services directed by a Qualified Registered Nurse who evaluates the particular nursing needs of each client and provides for the medical care and treatment that is indicated on the Department approved treatment planning document approved by the supervising practitioner. Reimbursement for psychological diagnostic services is included in the per diem.
  - b. Clinically Necessary Psychological Diagnostic Services: Testing and evaluation services must reasonably be expected to contribute to the diagnosis and plan of care established for the individual client. Testing and evaluation services may be performed by a Clinical Psychologist acting within his/her scope of practice. Clinical necessity must be documented by the program supervising practitioner.
  - c. Clinically Necessary Pharmaceutical Services: If medications are dispensed by the program, pharmacy services must be provided under the supervision of a registered pharmacy consultant; or the program may contract for these services through an outside licensed/certified facility. All medications must be stored in a special locked storage space and administered only by a physician, registered nurse, licensed practical nurse, or a staff person approved by the Nebraska Department of Health and Human Services, Division of Public Health as a Medication Aide.

- d. Clinically Necessary Dietary Services: The meal services provided must be supervised by a registered dietitian, based on the client's individualized diet needs. Programs may contract for these services through an outside licensed certified facility.
  - e. Transition and discharge planning must meet the requirements of 471 NAC 32-001.07A.
6. Optional Services: The program must provide two of the following optional services. The client must have a need for the services, the supervising practitioner must order the services, and the services must be a part of the client's treatment plan. The therapies must be restorative in nature, not prescribed for conditions that have plateaued or cannot be significantly improved by the therapy, or which would be considered maintenance therapy:
- a. Services provided or supervised by a licensed or certified therapist may be provided under the supervision of a qualified consultant or the program may contract for these services from a licensed/certified professional as listed below:
    - (1) Recreational Therapy;
    - (2) Speech Therapy;
    - (3) Occupational Therapy;
    - (4) Vocational Skills Therapy;
    - (5) Self-Care Services: Services supervised by a registered nurse or occupational therapist who is oriented toward activities of daily living and personal hygiene. This includes toileting, bathing, grooming, etc.
  - b. Psychoeducational Services: 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 abuse 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.
  - c. 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, i.e., case management type services.
  - d. Crisis Intervention (may be provided in home);
  - e. Social Skills Building;
  - f. Life Survival Skills;
  - g. Substance abuse prevention, intervention, or treatment by an appropriately licensed alcohol and drug counselor.
7. Provide appropriate conferences involving the youth's interdisciplinary treatment team, the parents, the referring agency, and the child, to review the case status and progress at least every month. This does not substitute for documentation requirements. The need for conferences with interested parties is indicated by the individual child's circumstances and needs, which may indicate conferences occurring more frequently. For wards of the Department, this need will be jointly determined with the case manager;

8. Allow for more than one type of activity to be scheduled at one time allowing for specialized and individualized treatment planning;
9. Provide a progress report to the referring agency, and the parents or legal guardian every month for the purpose of service coordination. For wards of the Department, monthly reports must be provided to the Division of Children and Family Services case manager. The documentation from the Monthly Treatment Plan review may serve this purpose;
10. The services of specialists in the fields of medicine, psychiatry, psychology, and education must be used as needed.

32-007.03G Annual Update/Renewal: The residential treatment center shall submit the following information with the provider application and agreement, and update/renew the information annually to coincide with submission of the cost report:

1. A written overview of the program's philosophy and objectives of treating children and adolescents including:
  - a. A description of each available service;
  - b. A list of treatment modalities available and the capacity for individualized treatment planning;
  - c. A statement of the qualification, education, and experience of each staff member providing treatment and the therapy service each provides;
  - d. A schedule covering the total number of hours that the program operates;
  - e. The cost report; and
  - f. The target population.
2. Confirmation that the staffing standards in 471 NAC 32-007.03E are met;
3. Copy of child caring agency licensure certificate; and
4. Copy of accreditation certificate.

The Division of Medicaid and Long-Term Care or its designee may request this information on an intermittent basis and the provider must comply by promptly supplying the requested information.

32-007.04 Covered Services: Medicaid limits payment for residential treatment services to those services for medically necessary to treat primary diagnoses. Medicaid covers residential services as delineated in 471 NAC 32-007 when the services are medically necessary and provide active treatment.

32-007.04A Pre-Admission Authorization: For residential treatment center services to be covered by Medicaid, the need for admission to this level of care must be determined by a supervising practitioner through a thorough Initial Diagnostic Interview and prior authorized through the Medicaid Division or its designee. For wards of the Department, consent for treatment for wards of the Department must be obtained from the Department case manager or supervisor. See 471 NAC 32-006.01, 32-006.03F, 32-006.04A, 32-006.05B.

32-007.04B Guidelines for Use of Residential Treatment Services for Children: A youth must have a diagnosable condition listed in the current diagnostic and statistics manual of the American Psychiatric Association (excluding V-codes and developmental disorders) for this level of care. NMAP applies the following guidelines to determine when residential treatment services for children or adolescents are medically necessary for a client:

1. The child/adolescent requires 24-hour awake supervision with high staff ratios;
2. Utilization of residential treatment services is appropriate for individualized treatment and is expected to improve the client's condition to facilitate moving the client to a less restrictive placement;
3. The child/adolescent's problem behaviors are persistent, unpredictable, and may jeopardize the health or safety of the client and/or others;
4. The child/adolescent's daily functioning must be significantly impaired in multiple areas, such as family relationships, education, daily living skills, community, health, etc.;
5. The child/adolescent has a documented history of previous placement disruptions due to on-going behaviors/psychiatric issues; and
6. Less restrictive treatment approaches have not been successful or are deemed inappropriate by the referring supervising practitioner.

32-007.04C Therapeutic Passes for Clients Involved in Residential Treatment Services: Therapeutic passes are an essential part of the treatment for client/families involved in residential treatment services. Documentation of the client's continued need for residential treatment services must follow overnight therapeutic passes. Therapeutic passes must be indicated in the treatment plan as they become appropriate. NMAP reimburses for only 60 therapeutic pass days per client per year. This includes all treatment services in which the client is involved during the year.

Therapeutic leave days are counted by the entity reimbursing for the care. Because the NMAP fee-for-service program reimburses for therapeutic leave days on a post-service basis and because providers have one year to bill for services, the Department cannot guarantee that an accurate account of the therapeutic leave days that have been used.

32-007.04D Vacations: If a residential treatment program takes the clients on a "vacation," NMAP will reimburse for those days under the following conditions -

1. The trip is prior authorized by the Division of Medicaid and Long-Term Care or its designee;
2. There is a clear statement of goals and objectives for the individual client's participation in the trip;
3. At least 50% of the scheduled treatment interventions must occur during the "vacation";
4. A clinical staff person must accompany the "vacation" trip; and
5. The "vacation" must be included in the treatment program.

NMAP will reimburse for up to seven "vacation" days per year for clients in residential treatment program.

#### 32-007.05 Additional Requirements

32-007.05A Work Experience: When a center has a work program, it must -

1. Provide work experience that is appropriate to the developmental age and abilities of the child/adolescent;
2. Differentiate between the chores that children/adolescents are expected to perform as their share in the process of living together, specific work assignments available to children/adolescents as a means of earning money, and jobs performed in or out of the center to gain vocational training;
3. Give children/adolescents some choice in their work experience and offer change from routine duties to provide a variety of experiences;
4. Not interfere with the child/adolescent's time for school, study periods, play, chores, sleep, normal community activities, visits with the family, or individual, group, or family therapy.
5. Children/adolescents may not be solely responsible for any major phase of the center's operation or maintenance, such as cooking, laundering, housekeeping, farming, or repairing; and
6. Comply with all state and federal labor laws.

32-007.05B Solicitation of Funds: A center may not use a child/adolescent for advertising, soliciting funds, or in any other way that may cause harm or embarrassment to the child/adolescent or the family. Written consent of the parent or guardian must be obtained before the center uses a child's picture, person, or name in any form of written, visual, or verbal communication. Before obtaining consent, the center shall advise the parent or guardian of the purpose for which it intends to use the child's picture, person, or name, and of the times and places when and where this use would occur.



32-007.05C Special Treatment Procedures: If a youth needs behavior management and containment beyond unlocked time outs or redirection, special treatment procedures may be utilized. Special treatment procedures in psychiatric RTC's are limited to physical restraint, locked time out (LTO), and a locked unit. Mechanical restraints and pressure point tactics are not allowed. Parents or legal guardians or the Department 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:

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

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

32-007.05D Medical Care: The center shall ensure that the following medical care is provided for each child/adolescent:

1. Each child/adolescent must receive a medical examination (EPSDT/Health Check exam) before or at the time of admission;
2. Each child/adolescent must have current immunizations as required by the Nebraska Department of Health and Human Services;
3. The center shall arrange with a physician and a psychiatrist for the medical and psychiatric care of the clients;
4. Each child/adolescent must have a medical examination annually as allowed in 471 NAC 33-000 ff.;

5. The center shall inform staff members of what medical care, including first aid, may be given by staff without specific physician orders. Staff must be instructed on how to obtain further medical care and how to handle emergency cases. The center shall ensure that -
  - a. Staff members on duty must have satisfactorily completed current first aid and cardiopulmonary resuscitation training and have on file at the center a certificate of satisfactory completion as required by Department of Health and Human Services, Division of Public Health regulations;
  - b. Each staff member must be able to recognize the common symptoms of illnesses in children/adolescents and to note any marked physical defects of children.
  - c. A sterile clinical thermometer, a complete first aid kit, and clearly posted emergency phone numbers must be available, according to Department of Health and Human Services.

32-007.05E Hospital Admissions: The center shall make arrangements for the emergency admission of children from the center in case of serious illness, emergency, or psychiatric crisis. Parents, legal guardians, or the Department case manager or the case manager's supervisor must give permission and consent to treat for admission.

In the event that a client does require hospitalization while in a residential treatment center, NMAP will reimburse the treatment program for up to 15 days per hospitalization. This reimbursement is only available if the treatment placement is not used by another client.

32-007.05F Hospitalization or Death Reports: The center shall report any accident or illness requiring hospitalization to the parents or guardian immediately. The center shall immediately report any death to the parents or guardian, the Division of Medicaid and Long-Term Care, a law enforcement agency, and the county coroner. If the child is a Department ward, see 474 NAC 4-009.28D8.

32-007.05G Dental Care: Each child/adolescent must have an annual dental examination. If a child/adolescent has not had a dental exam in the twelve months before admission, an examination must occur within 90 days following admission. See 471 NAC 6-000 and 33-000 and 474 NAC 6-005.26F.

32-007.05H General Health: The center shall ensure the following:

1. Each child/adolescent must have enough sleep for the child/adolescent's age and physical and emotional condition at regular and reasonable hours, and under conditions conducive to rest. While clients are asleep, at least one staff member must be within hearing distance;
2. Children/adolescents must be encouraged and helped to keep themselves clean;
3. Bathing and toilet facilities must be properly maintained and kept clean;
4. Each child/adolescent must have a toothbrush, comb, an adequate supply of towels and washcloths, and personal toilet articles;
5. Menus must provide for a varied diet that meets a child/adolescent's daily nutritional requirements;
6. Each child/adolescent must have clothing for their exclusive use. The clothing must be comfortable and appropriate for the current weather conditions; and
7. The center must provide safe, age-appropriate equipment for indoor and outdoor play.

See 471 NAC 33-000.

32-007.05J Education: Educational services, when required by law, must be available. Education services must only be one aspect of the treatment plan, not the primary reason for admission or treatment. Educational services are not eligible for payment by the NMAP.

32-007.05K Religious Education: Children/adolescent must be provided with an opportunity to receive instruction in their religion. No child/adolescent may be required to attend religious services or to receive religious instructions if the child/adolescent chooses not to attend the services or receive instruction.

32-007.05L Discipline: Discipline must be diagnostic and remedial rather than punitive. Corporal punishment, verbal abuse, and derogatory remarks about the child/adolescent, the family, religion, or cultural background are prohibited. A child/adolescent may not be slapped, punched, spanked, shaken, pinched, or struck with an object by any staff of the center. Only staff members of the center may discipline children (see 474 NAC 6-005.26K) while in treatment.

32-007.05M Transition and Discharge Planning: Whenever a child or adolescent is transferred from one setting to another, discharge planning must be performed and documented, beginning at the time of admission (see 471 NAC 32-001.07A and 474 NAC 6-005.27H).

Facilities must meet the following standards regarding discharge planning:

1. Discharge planning must be based on the multidisciplinary treatment plan designed to achieve the client's discharge from residential treatment status to a less restrictive level of care at the most appropriate time;
2. Discharge planning must address the client's need for ongoing treatment, continuing education, and support for normal development following discharge;
3. Discharge planning must include identification of and transition into services needed following discharge;
4. The residential treatment facility shall arrange for prompt transfer of appropriate records and information to ensure continuity of care following the client's discharge;
5. A written discharge summary must be provided as part of the clinical record; and
6. The client's family and caseworker must be active participants in discharge planning. This participation must be clearly documented in the client's record.

32-007.05N Notification of Runaway Children: See 390 NAC 7-001.05.

32-007.05P Interstate Compact on the Placement of Children: The center shall comply with the interstate compact on the placement of children (see 474 NAC 6-005.27J).

32-007.05Q Medications: The center may possess a limited quantity of nonprescription medications and administer them under the supervision of designated staff. The center must follow all applicable regulations through the Department of Health and Human Services, Division of Public Health for storing and administering medications.

The center shall have written policies governing the use of psychotropic medications. Parents or the guardian of a client who receives psychotropic medication must be informed of the benefits, risks, side effects, and potential effects of medications. A parent or legal guardian's written informed consent for use of the medication must be obtained before giving the medication and filed in the client's record.

A child/adolescent's medication regime must be reviewed by the attending physician at least every seven days for the first 30 days and at least every 30 days thereafter.

32-007.06 Individual Treatment: To be covered by Medicaid, individual treatment services must include -

1. Program philosophy: Residential treatment facilities must provide intensive family-centered, community-based, developmentally appropriate services under the direction of a supervising practitioner.
  - a. These services must be able to meet the special needs of families, including the "identified client" in the treatment facility. Families must be involved in treatment and discharge planning. For wards of the Department, the case manager must also be involved in treatment and discharge planning.
  - b. The program intensity must be such that direct care staff, the client in treatment, and/or the client's family have access to professional staff on an "as needed" basis, determined by the client's condition.
2. Active treatment, which must be -
  - a. Treatment provided under a multi-disciplinary treatment plan reviewed and approved by the supervising practitioner. This plan will be developed within 14 days of admission by a multi-disciplinary team of professional staff members. The treatment plan must be for a primary psychiatric diagnosis and must be based on a thorough evaluation of the client's restorative needs and the client's potential. The treatment plan must be reviewed at least every 30 days by the multi-disciplinary team.

The goals and objectives documented on the treatment plan must reflect the recommendations from the Initial Diagnostic Interview, the supervising practitioner and the therapist. The treatment interventions provided must reflect these recommendations, goals, and objectives. Evaluation of the treatment plan by the therapist and the supervising practitioner should reflect the client's response to the treatment interventions based on the recommendations, goals and objectives.
  - b. In compliance with 471 NAC 32-001.07, Treatment Planning; and
  - c. In compliance with 471 NAC 32-001.06, Active Treatment.
3. Medically necessary services, which must be an appropriate level of care based on documented Initial Diagnostic Interview including a comprehensive diagnostic workup and supervising practitioner-ordered treatment.

32-007.07 Documentation in the Client's Clinical Record: The center must maintain accurate clinical records indicating the degree and intensity of the treatment provided to clients who receive services in the residential treatment facility. For residential services, clinical records must stress the treatment intervention components of the clinical record, including history of findings and treatment provided for the psychiatric condition for which the client is in the facility. The clinical record must include the requirements stated in 471 NAC 32-001.05 and -

1. The identification data, including the client's legal status (i.e., voluntary admission, Board of Mental Health commitment, court mandated);
2. A provisional or admitting diagnosis which is determined for every client at the time of admission and includes the diagnoses of intercurrent diseases as well as the psychiatric diagnoses;

3. The statements of others regarding the client's problems and needs, as well as the client's statement of their problems and needs;
4. The Initial Diagnostic Interview, including a medical/psychiatric history, which contains a record of mental status and notes the onset of illness/problems, the circumstances leading to admission, attitudes, behavior, estimate of intellectual functioning, memory functioning, orientation, and an inventory of the client's strengths in a descriptive, not interpretative, fashion;
5. A complete psychological evaluation;
6. A complete neurological examination, when indicated;
7. A social history sufficient to provide data on the client's relevant past history, present situation, social support system, community resource contacts, and other information relevant to good treatment and discharge planning;
8. A thorough family assessment;
9. Reports of consultations, psychological evaluations, electroencephalograms, dental records, and special studies;
10. The treatment received by the client, which is documented in a manner and with a frequency to ensure that all active therapeutic efforts, such as individual, group, and family psychotherapy, drug therapy, milieu therapy, occupational therapy, recreational therapy, nursing care, and other therapeutic interventions, are included;
11. Progress notes must be recorded by all professional staff and, when appropriate, others significantly involved in active treatment modalities, following each contact. The frequency is determined by the individual treatment plan and the condition of the client, but should be recorded at least daily. Progress notes must contain a concise assessment of the client's progress and recommendations for revising the treatment plan as indicated by the client's condition. Child care workers must maintain 24-hour documentation of a client's whereabouts and activities;
12. The transition plan and discharge summary, including a summary of the client's and family's treatment, recommendations for appropriate services concerning follow-up, and a brief summary of the client's condition on discharge;
13. The psychiatric diagnosis contained in the final diagnosis written in the terminology of the American Psychiatric Association's Diagnostic and Statistical Manual; and
14. The client's response to therapeutic leave days prescribed by the supervising practitioner under the treatment plan. The client's, family's, or guardian's response to time spent outside the facility must be entered in the client's clinical record.

All documents from the client's medical record submitted to the Division of Medicaid and Long-Term Care must contain sufficient information for identification (i.e., client's name, date of service, provider's name).

32-007.08 Utilization Review: All facilities must have a utilization review protocol for their services.

32-007.09 Inspection of Care (IOC): The Division of Medicaid and Long-Term Care or its designee's inspection of care team will conduct inspection of care reviews for psychiatric residential treatment facilities. See 471 NAC 32-001.09 and 471 NAC 32-001.10.

32-007.10 Documentation for Claims: The following documentation is required and kept in the client's clinical record for all claims for residential treatment services. The facility will be notified in writing if that occurs:

1. The treatment plan;
2. Orders by the supervising practitioner; and
3. Progress notes for all disciplines.

All claims are subject to utilization review by the Department prior to payment.

32-007.10A Exception: Additional documentation from the client's clinical record may be requested by the Department prior to considering authorization of payment.

32-007.11 Costs Not Included in the Residential Treatment Per Diem: The mandatory and optional services are considered to be part of the per diem for residential treatment services. The following charges can be reimbursed separately from the residential treatment per diem when the services are necessary, part of the client's overall treatment plan, and in compliance with NMAP policy:

1. Direct client services performed by the supervising practitioner;
2. Prescription medications (including injectable medications);
3. Direct client services performed by a physician other than the supervising practitioner; and
4. Treatment services for a physical injury or illness provided by other professionals.

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

32-007.12 Procedure Code and Description for Residential Treatment Services: HCPCS/CPT procedure codes used by NMAP are listed in the Nebraska Medicaid Practitioner Fee Schedule at 471-000-532.

32-008 Inpatient Psychiatric Services for Individuals Under Age 19 in Psychiatric Residential Treatment Facilities

32-008.01 Psychiatric Residential Treatment Facilities (PRTFs) for Children/Adolescents: A Psychiatric Residential Treatment Facility (PRTF) is a facility, other than a hospital, that provides inpatient psychiatric services to individuals under the age of 19. A PRTF must provide the inpatient psychiatric services under the direction of a physician, must be accredited and must comply with all the requirements of applicable state and federal regulations.

32-008.02 Prior Authorization: In order for an admission to a PRTF to be reimbursed by Medicaid, the individual must meet the Certification of Need for Services requirements set forth in 32-008.03 and be prior authorized by Medicaid or its designee. Prior authorization applies to all admissions described in 32-008.04.

32-008.03 Certification of Need for Services: A team specified in Section 32-008.04 must certify, prior to admission, that:

1. Ambulatory care resources available in the community do not meet the treatment needs of the individual;
2. Proper treatment of the individual's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
3. The services can reasonably be expected to improve the individual's condition or prevent further regression so that the services will no longer be needed.

32-008.04 Team Certifying Need for Services: Certification of the need for services specified in 32-008.03 must be made by an independent team that:

1. Includes a physician;
2. Has competence in diagnosis and treatment of mental illness, preferably in child psychiatry; and
3. Has knowledge of the individual's situation.

32-008.04A Individuals Who Become Eligible for Medicaid While in PRTF: For an individual who applies for Medicaid while in the PRTF, the certification must be:

1. Made by the team responsible for the Plan of Care as specified in 32-008.07; and
2. Cover any period before application for which claims are made.

32-008.04B Emergency Admissions: For emergency admissions, the certification must be made by the team responsible for the Plan of Care within 14 days after admission.

32-008.05 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 32-008.06, that is developed and implemented no later than 14 days after admission and is designed to achieve the individual's discharge from inpatient status at the earliest possible time.



32-008.06 Individual Plan of Care: The plan of care means a written plan developed for each individual to improve his/her condition to the extent that inpatient care is no longer necessary. The plan of care must:

1. Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the individual's situation and reflects the need for inpatient psychiatric care;
2. Be developed by a team of professionals specified in 32-008.07 in consultation with the individual and the parents, legal guardian or others in whose care the individual will be released after discharge;
3. State treatment objectives;
4. Prescribe an integrated program of therapies, activities and experiences designed to meet the objectives; and
5. Include post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the individual's family, school and community upon discharge. The discharge plan must:
  - a. Identify the custodial parent or custodial caregiver anticipated at discharge;
  - b. Identify the school the patient will attend;
  - c. Include individualized educational program (IEP) recommendations as necessary;
  - d. Outline the aftercare treatment plan; and
  - e. List barriers to community reintegration and progress toward resolving these barriers since the last review. Include the needs of the custodial parent or custodial caregiver.

32-008.07 Team Developing Individual Plan of Care:

1. The individual plan of care shall be developed by an interdisciplinary team of physicians and other personnel who are employed by, or provide services to individuals in the facility.
2. Based on education and experience, preferably including competence in child psychiatry, the team must be capable of:
  - a. Assessing the individual's immediate and long-range therapeutic needs, developmental priorities and personal strengths and liabilities;
  - b. Assessing the potential resources of the individual's family;
  - c. Setting treatment objectives; and
  - d. Prescribing therapeutic modalities to achieve the plan's objectives.
3. The team must include, as a minimum, either:
  - a. A Board-eligible or Board-certified psychiatrist; or
  - b. A licensed psychologist and a physician licensed to practice medicine or osteopathy; or
  - c. A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases and a licensed psychologist.
4. The team must also include one of the following:
  - a. A psychiatric social worker;
  - b. A licensed registered nurse with specialized training or one year's experience in treating mentally ill individuals;

- c. A licensed occupational therapist who has specialized training or one year of experience in treating mentally ill individuals.
- d. A licensed psychologist.

32-008.08 Reports of Evaluations and Plans of Care: A written report of each evaluation and plan of care must be entered in the individual's record:

1. At the time of admission; or
2. If the individual is already in the PRTF, immediately upon completion of the evaluation or plan.

32-008.09 Review of Plan of Care: The Plan of Care must be reviewed every 30 days by the team specified in 32-008.07, to:

1. Determine that services being provided continue to be required on an inpatient basis, and
2. Recommend changes in the plan as indicated by the individual's overall progress from the treatment provided at this level of care.

32-008.10 Treatment Services Provided by the PRTF: Providers of PRTF services shall provide 40 hours of psychotherapy and other treatment interventions per week. The following services and frequency of services are included in the PRTF rate and must be available to the individual unless clinically contraindicated:

1. Twice weekly individual psychotherapy and/or substance abuse counseling;
2. Minimum three times a week group psychotherapy and/or substance abuse counseling;
3. Weekly family psychotherapy and/or family substance abuse counseling. A family therapy session is provided on the day of admission and the day prior to discharge;
4. Occupational therapy as clinically indicated;
5. Physical therapy as clinically indicated;
6. Speech therapy as clinically indicated;
7. Laboratory services;
8. Transportation; and
9. Medical Services, as necessary; and
10. Nursing service availability 7 days a week, 365 days a year by an onsite nurse during awake hours and by an on-call availability during sleep hours.

32-008.11 Psychoeducation Services Provided in PRTF: Psychoeducational services must be available from the PRTF and must be modified to meet the unique treatment needs of the individual as described in the individual's Plan of Care:

1. Crisis intervention and aftercare planning;
2. Life survival skills as clinically indicated;
3. Social skills building;
4. Substance abuse prevention interventions;
5. Self-care services as clinically indicated;

6. Medication education, compliance and information regarding the effectiveness of medication;
7. Health care issues which may include nutrition, hygiene and personal wellness;
8. Vocational/career planning as clinically indicated; and
9. Recreational activity (recreational activity 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).

32-008.12 Individual Participation in PRTF Services: Every individual need not partake in all treatment services that are available in the PRTF if such services are clinically contraindicated. If individual, group or family psychotherapy services are not appropriately beneficial to the individual's need and Plan of Care, the Plan of Care shall identify the rationale for this omission. However, in no case should a child/adolescent receive less than 40 hours of PRTF services each week.

32-008.13 Staffing Standards for PRTFs: A PRTF shall be available 24 hours a day, 7 days a week, 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.

32-008.13A Supervising Practitioner: The PRTF Supervising Practitioner shall be a licensed physician.

32-008.13B Program/Clinical Director: A program/clinical director shall be a LMHP, licensed RN, licensed APRN, LIMHP, licensed physician with a specialty in psychiatry, or licensed psychologist. Dual-credentialing (e.g., LMHP/LADC or LMHP/PLADC) is required for PRTF services when co-occurring conditions (e.g. mental health and substance abuse) occur.

The Program/Clinical Director shall have two years professional experience in a treatment setting similar to a PRTF. The Program/Clinical Director may not also serve in the role of the program's therapist.

32-008.13C PRTF Therapist: A PRTF therapist shall be a licensed practitioner whose scope of practice includes mental health and/or substance abuse services, including a LMHP, LIMHP, PLMHP, LADC, licensed psychologist, provisionally licensed psychologist, licensed APRN, or licensed physician with a specialty in psychiatry.

32-008.13D Registered Nurse or Advanced Practicing Registered Nurse (RN or APRN): Nursing services shall be provided by a Registered Nurse or APRN licensed by the State in which she or he practices.

32-008.13E Direct Care Staff: Direct care staff shall meet the following requirements: Be 21 years of age or older and at least three years older than the oldest resident and have a high school diploma or its equivalent. Direct care staff shall be appropriately trained and responsible for basic interaction care such as supervision, daily living care and mentoring of the residents as well as assisting in the implementation of the plan of care that is within their scope of practice.

32-008.14 Restraint and Seclusion: Restraint and seclusion activities utilized by the PRTF shall be in compliance with federal standards for restraint and seclusion.

32-008.15 Services Provided Outside the PRTF: The following services must be available to the individual and may be billed separately to Medicaid:

1. Medically necessary services and/or supplies, including dental, vision, diagnostic radiology and prescribed medications, not otherwise included in the PRTF rate when that care is reflected in the plan of care.
2. The PRTF shall:
  - a. Arrange for and oversee the provision of such services and/or supplies;
  - b. Maintain all medical records of care furnished to the individual; and
  - c. Ensure that all services and/or supplies are furnished under the direction of a physician.

32-009 Inpatient Mental Health Services for Clients 20 and Younger in Institutions for Mental Disease (IMD's): Inpatient mental health services in an Institution for Mental Disease (IMD's) are available to clients age 20 and younger when the client participates in a HEALTH CHECK (EPSDT) screen, and the treatment is medically necessary. Inpatient mental health services in an IMD must be family centered and community based culturally competent, and developmentally appropriate.

Services for wards of the Department must be prior-authorized by and consent for treatment must be obtained from the ward's case manager or the case manager's supervisor.

32-009.01 Legal Basis: The Nebraska Medical Assistance Program (NMAP) covers IMD services under 42 CFR 431.620(b), 435.1009; 440.140; 440.160; Part 441, Subparts C and D; Part 447, Subparts B and C; Part 456, Subparts D and I; and Part 482. The Department provides IMD services under the Family Policy Act, Sections 43-532 through 534. Reissue Revised Statute of Nebraska, 1943.

32-009.02 Definition of an IMD: 42 CFR 435.1009 defines an IMD as "an institution that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for the mentally retarded is not an institution for mental diseases." This is limited to free-standing facilities which are not excluded units of acute care hospitals.

32-009.03 Covered Services: Under 42 CFR 440.160, NMAP covers services in IMD's for individuals age 20 and younger.

32-009.04 Standards for Participation: To participate in the NMAP, the IMD must -

1. Be in conformity with all applicable federal, state, and local laws;
2. Be licensed as a hospital by the Nebraska Department of Health and Human Services, Division of Public Health or the licensing agency in the state where the IMD is located;
3. Be certified as meeting the conditions of participation for hospitals in 42 CFR Part 482;
4. Be accredited by the Joint Commission of Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Association (AOA), and submit a copy of the most recent accreditation survey with Form MC-20;
5. Meet the definition of an IMD as stated in 471 NAC 32-009.02 (above);
6. Meet the program and operational definitions and criteria contained in the Nebraska Department of Health and Human Services Manual;
7. Meet the current JCAHO or AOA standards of care; and
8. Meet all requirements in 471 NAC 32-001 and 471 NAC 32-008.

32-009.04A Provider Agreement: The provider shall complete Form MC-20 and submit the form, along with a copy of its current JCAHO or AOA accreditation survey, program, policies, and procedures to the Department to enroll in NMAP as a provider. If approved, the Department notifies the IMD of its provider number.

32-009.04B Annual Update: With the annual cost report, the provider shall submit a copy of all program information, their most recent license and accreditation certificates, and any other information specifically requested by the Department. Claims will not be paid if this has not been received and approved.

32-009.04C Monthly Reports: The IMD shall submit a monthly report to the Division of Medicaid and Long-Term Care. The report must contain -

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

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

32-009.04D Record Requirements: Transfer to another IMD or readmission constitutes a new admission for the receiving facility.

The psychiatrist shall complete, sign, and date Form MC-14 within 48 hours after admission. If an individual applies for assistance while in the facility, copies of the admission notes and plan of care must be attached to the signed Form MC-14 to certify that inpatient services are or were needed.

32-009.04D1 An Individual Who Applies For NMAP While in the IMD: For an individual who applies for NMAP while in the IMD, the certification must be -

1. Made by the team that develops the individual plan of care (see 471 NAC 32-009.09F);
2. Cover any period before application for which claims are made.

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

32-009.05 General Definitions: The following definitions are used in this section:

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

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

Inpatient Hospital Services for Individuals Age 20 or Younger in Institutions for Mental Disease (IMD's): Services provided under the direction of a psychiatrist for the care and treatment of clients age 20 and younger in an institution for mental disease that meets the requirements of 42 CFR 440.160.

Inspection of Care Team: The Department or designee's inspection of care team, consisting of a psychiatrist knowledgeable about mental institutions, a qualified registered nurse, and other appropriate personnel as necessary who conduct inspection of care reviews under 42 CFR 456.600-614 and 471 NAC 32-009.07 ff.

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

32-009.06 Payment for IMD Services: See 471 NAC 10-010.03 ff.

32-009.06A Therapeutic Passes from Institution for Mental Disease Settings: For some psychiatric clients, therapeutic passes are an essential part of treatment. For those clients, documentation of the client's continued need for psychiatric care must follow the overnight therapeutic passes. Payment for hospitalization beyond a second pass is not available.

32-009.06B Unplanned Leaves of Absence from Institution for Mental Disease Settings: Payment for hospitalization during an unplanned leave of absence from inpatient settings is not available. If a client returns to a hospital after an unplanned absence, the readmission must be approved by the Department contracted peer review organization or management designee.

32-009.07 Inspections of Care: Under 42 CFR 456, Subpart I, the Department or designee's inspection of care team shall periodically inspect the care and services provided to clients in each IMD under the following policies and procedures.

32-009.07A Inspection of Care Team: The inspection of care team must meet the following requirements:

1. The inspection of care team must have a psychiatrist who is knowledgeable about mental institutions and other appropriate mental health and social service personnel;
2. The team must be supervised by a physician, but coordination of the team's activities remains the responsibility of the Division of Medicaid and Long-Term Care or their designee;
3. A member of the inspection of care team may not have a financial interest in any institution of the same type in which s/he is reviewing care but may have a financial interest in other facilities or institutions. A member of the inspection of care team may not review care in an institution where s/he is employed, but may review care in any other facility or institution.
4. A physician member of the team may not inspect the care of a client for whom s/he is the attending physician.
5. There must be a sufficient number of teams so located within the state that on-site inspections can be made at appropriate intervals in each facility caring for clients.

32-009.07B Frequency of Inspections: The inspection of care team and the Department shall determine, based on the quality of care and services being provided in a facility and the condition of clients in the facility, at what intervals inspections will be made. However, the inspection of care team shall inspect the care and services provided to each client at least annually, and/or more frequently as determined by the Inspection of Care team.



32-009.07C Notification Before Inspection: No facility may be notified of the time of inspection more than 48 hours before the scheduled arrival of the inspection of care team. The review team may make unannounced inspections at their discretion.

32-009.07D Personal Contact With and Observation of Recipients and Review of Records: For clients age 20 and younger, the team's inspection must include -

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

32-009.07E Determinations by the Team: The inspection of care team shall determine in its inspection whether -

1. The services available in the IMD are adequate to -
  - a. Meet the health needs of each client; and
  - b. Promote his/her maximum physical, mental, and psychosocial functioning;
2. It is necessary and desirable for the client to remain in the IMD;
3. It is feasible to meet the client's health needs through alternative institutional or noninstitutional services; and
4. Each client age 20 or younger in a psychiatric facility is receiving active treatment as defined in 42 CFR 441.154 and 471 NAC 32-009.05.

If, after an inspection of care is complete, the inspection of care team determines that a follow-up visit is required to ensure adequate care, a follow-up visit may be initiated by the team. This will be determined by the inspection of care team and will be noted in the inspection of care report.

32-009.07F Basis for Determinations: Under 42 CFR 456.610, in making the determinations by the team on the adequacy of services and other related matters, the team will determine what items will be considered in the review. This will include, but is not limited to, items such as whether -

1. The psychiatric and medical evaluation, any required social and psychological evaluations, and the plan of care are complete and current; the plan of care, and when required, the plan of rehabilitation are followed; and all ordered services, including dietary orders, are provided and properly recorded.;
2. The attending physician reviews prescribed medications at least every 30 days;
3. Test or observations of each client indicated by his/her medication regimen are made at appropriate times and properly recorded;
4. Physician, nurse, and other professional progress notes are made as required and appear to be consistent with the observed condition of the client;

5. The client receives adequate services, based on such observations as -
  - a. Cleanliness;
  - b. General physical condition and grooming;
  - c. Mental status;
  - d. Apparent maintenance of maximum physical, mental, and psychosocial function;
6. The client receives adequate rehabilitative services, as evidenced by -
  - a. A planned program of activities to prevent regression; and
  - b. Progress toward meeting objectives of the plan of care;
7. The client needs any services that are not furnished through the IMD or through arrangements with others;
8. The client needs continued placement in the IMD or there is an appropriate plan to transfer the client to an alternate method of care, which is the least restrictive, most appropriate environment that will still meet the client's needs.
9. Involvement of families and/or legal guardians (see 471 NAC 32-001); and
10. The facility's standards of care and policy and procedure meets the requirements for adequacy, appropriateness, and quality of services as they relate to individual Medicaid clients, as required by 42 CFR 456.611(b)(1).

32-009.07G Reports on Inspections: The inspection of care team shall submit a report to the Administrator of the Medicaid Division on each inspection. The report must contain the observations, conclusions, and recommendations of the team concerning -

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

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

32-009.07H Copies of Reports: Under 42 CFR 456.612, the Department shall send a copy of each inspection report to -

1. The facility inspected;
2. The IMD's utilization review committee;
3. The Nebraska Department of Health and Human Services, Division of Public Health; and
4. The Nebraska Department of Health and Human Services, Division of Behavioral Health.

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

32-009.07J Facility Response: Within 15 days following the receipt of the inspection of care team's report, the IMD shall respond to the Central Office in writing, and shall include the following information in the response:

1. A reply to any inaccuracies in the report. Written documentation to substantiate the inaccuracies must be sent with the reply. The Department will take appropriate action to note this in a follow-up response to the facility;
2. A complete plan of correction for all identified Findings and Recommendations;
3. Changes in level of care or discharge of individual clients;
4. Action to individual client recommendations; and
5. Projected dates of completion on each of the above.

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

At the facility's request, copies of the facility's response will be sent to all parties who received a copy of the inspection report in 471 NAC 32-009.07H.

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

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

32-009.07K Department Action on Reports: The Department will take corrective action as needed based on the report and recommendations of the team submitted under this subpart.

32-009.07L Appeals: See 471 NAC 2-003 ff. and 465 NAC 2-001.02 ff. and 2-006 ff.

32-009.07M Failure to Respond: If the IMD fails to submit a timely and/or appropriate response, the Department may take administrative sanctions (see 471 NAC 2-002 ff.) or may suspend NMAP payment for an individual client or the entire payment to the facility.

32-009.08 Inpatient Mental Health Services for Individuals Age 20 and Younger in an IMD: NMAP covers inpatient mental health services in an IMD for individuals age 20 and younger under 42 CFR 440.160. The following requirements must be met to receive NMAP payment for these services.

32-009.08A Admission Criteria: See 471 NAC 32-008.05.

32-009.08B Admission Evaluation: A psychiatrist shall make an admission evaluation when the client is admitted to the hospital. The admission evaluation must include -

1. 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 client;
2. A determination of the range and kind of services required; and
3. If all admission criteria have been met, this evaluation must include an initial treatment plan.

32-009.08C Treatment Plan Requirements:

1. The treatment plan must meet the guidelines in 471 NAC 32-001 and in 42 CFR 441.155 and 441.156; and
2. The treatment plan must be developed by the psychiatrist and the Interdisciplinary Team defined in 471 NAC 32-009.08H.

32-009.08C1 Review of Plan of Care: Under 42 CFR 441.155(c), the facility interdisciplinary team shall review the plan of care every 30 days to -

1. Determine that services being provided are or were required on an inpatient basis; and
2. Recommend changes in the plan of care as indicated by the client's overall adjustment as an inpatient.

This review also serves as the recertification of need for services.

The individual plan of care must be developed by the facility interdisciplinary team.

32-009.08D Prior Authorization Procedures: IMD services for clients age 20 and younger must be prior-authorized as follows:

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

32-009.08D1 Transfers: Transfer to another IMD or a readmission constitutes a new admission for the receiving facility. This procedure must be followed for each transfer or readmission.

32-009.08E Certification of Need for Services: For persons becoming Medicaid eligible after admission, in accordance with 42 CFR 441.152, the facility interdisciplinary team shall certify that -

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

The certification must be made at the time of admission, or if the individual applies for the NMAP while in the IMD, before the Department authorizes payment. This is accomplished by completion of Form MC-14. The form must be signed by the team physician/psychiatrist making the determination. A copy of the physician referral must accompany the completed MC-14.

32-009.08F Initial Certification: A psychiatrist shall pre-certify, at the time of admission, that the client requires inpatient services in a psychiatric hospital. The psychiatrist shall complete Form MC-14 at the time of admission or within 48 hours of admission. If the individual applies for NMAP while in a psychiatric hospital, the psychiatrist shall certify the client's needs before the Department authorizes payment.

32-009.08G Sixty-Day Recertification: A psychiatrist shall recertify, in the client's record, the client's need for continued care in a mental hospital or need for alternative arrangements at least every 60 days after the initial certification.

32-009.08H Interdisciplinary Plan of Care: The psychiatrist and the facility interdisciplinary team shall develop and implement an individual written plan of care for each client within 48 hours after the client's admission. This plan of care must be placed in the client's chart when completed. The written plan of care must include -

1. Diagnoses, symptoms, complaints, and complications indicating the need for admission;
2. A description of the client's functional level;
3. Objectives;
4. Any orders for -
  - a. Medications;
  - b. Treatments;

- c. Restorative and rehabilitative services;
  - d. Activities;
  - e. Therapies;
  - f. Social services;
  - g. Diet; and
  - h. Special procedures recommended for the client's health and safety;
5. Plans for continuing care, including review and modification of the plan of care;
  6. Appropriate medical treatment in the IMD every 60 days;
  7. Appropriate social services every 60 days; and
  8. Plans for discharge, including referrals for outpatient follow-up care.

Care plans must address family involvement.

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

32-009.08J Required Psychiatrist Services: The client must be treated by a psychiatrist at least six out of seven days, or frequently as medically necessary and the interaction must be documented in the client's medical record.

32-009.08K Facility Interdisciplinary Plan of Care Team Review: The attending or staff psychiatrist and other personnel involved in the client's care shall review each plan of care at least every 30 days. The client's record must contain documentation of the 30-day interdisciplinary team review.

32-009.08L Admission Evaluation: IMD staff shall develop an admission evaluation for each client within 30 days after the client's admission. This evaluation must be placed in the client's record when completed. The admission evaluation must include -

1. The Form MC-14 (see 471 NAC 32-009.08E).
2. A medical evaluation, including -
  - a. Diagnosis;
  - b. Summary of current medical findings;
  - c. Medical history;
  - d. Mental and physical functional capacity;
  - e. Prognosis;
  - f. The psychiatrist's recommendation concerning the client's admission to the mental hospital or the client's need for continued care in the mental hospital, if the client applies for NMAP while in the mental hospital;
3. A psychiatric evaluation;
4. A social evaluation;
5. An initial plan of care sufficient to meet the client's needs until the facility interdisciplinary team has developed the individual written plan of care.

32-009.08M Discharge Planning: The IMD shall make available to the psychiatrist current information on resources available for continued out-of-hospital care of patients and shall arrange for prompt transfer of appropriate medical and nursing information to ensure continuity of care upon the client's discharge. The IMD is responsible for discharge planning. In cooperation with community regional mental health programs, the IMD shall -

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

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

32-009.09 Payment for Inpatient Mental Health Services in an Institution for Mental Disease:  
See 471 NAC 10-010.03 ff., 32-008.09, and 32-008.12.

32-009.10 Other Regulations: In addition to the policies regarding mental health services, all regulations in the Nebraska Department of Health and Human Services Manual apply, unless stated differently in this section.