20-000 PSYCHIATRIC SERVICES FOR INDIVIDUALS AGE 21 AND OLDER

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

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

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

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

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

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

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

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

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

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

20-001.06 Culturally Competent Care: Providers of psychiatric services for individuals age 20 and over must be culturally competent. This includes awareness, acceptance, and respect of differences and continuing self-assessment regarding culture. Cultural competence also includes careful attention to the dynamics of differences and how they affect interactions, assumptions, and the delivery of services. Providers also demonstrate cultural competence through continuous expansion of cultural knowledge and resources through training, readings, etc., and by providing a variety of adaptations to service models in order to meet the needs of different cultural populations.

Culturally competent providers hire unbiased employees, seek advice and consultation from the minority community, and actively decide whether or not they are capable of providing services to clients from other cultures. They provide support for staff to become comfortable working in cross-cultural situations and understand the interplay between policy and practice and are committed to policies that enhance services to diverse clientele.

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

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

20-001.09 Provider Enrollment

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

Refer to the Standards for Participation section in each subpart.

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

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

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

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

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

20-001.11 Quality Assurance and Utilization Review: All providers participating in NMAP have agreed to provide services under the requirements of 471 NAC 2-001.03, Provider Agreements. If there is any question or concern about the quality of service being provided by an enrolled provider, the Department may perform quality assurance and utilization review activities, such as on-site visits, to verify the quality of service. If the provider or the services do not meet the standards of this chapter and the specific level of care, the provider may be subject to administrative sanctions under 471 NAC 2-002 ff. or denial of provider agreement for good cause under 471 NAC 2-001.02A. The Department may request a refund for all services not meeting Chapter 20 requirements.

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

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

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

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

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

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

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

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

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

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

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

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

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

Supervisory contact may occur in a group setting.

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

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

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

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

2. Psychiatricly trained physician extenders may not supervise services in place of the physician, but may provide direct care as allowed by the scope of practice guidelines set by the Nebraska Department of Health and Human Services, Division of Public Health ~~Regulation and Licensure~~ and the practice agreement of each individual. A copy of the practice agreement must be submitted at the time of application for enrollment.
3. Licensed Independent Mental Health Practitioners (LIMHP) may provide direct care as allowed by the scope of practice guidelines set by Nebraska Department of Health and Human Services, Division of Public Health.

~~3~~4. Allied Health Therapists: All psychotherapy services provided by allied health therapists must be prescribed by the supervising practitioner and provided under his/her supervision. All allied health therapists must have knowledge of the interactional systems within families.
Allied health therapists include:
   a. Specially Licensed Psychologists: Persons who are specially licensed as psychologists through the Nebraska Department of Health and Human Services, Division of Public Health ~~Regulation and Licensure~~ or the appropriate licensing agency of the state in which s/he practices;
   b. Licensed Mental Health Practitioners: Persons who are licensed as mental health practitioners by the Nebraska Department of Health and Human Services, Division of Public Health ~~Regulation and Licensure~~ or the appropriate licensing agency of the state in which s/he practices;

c. Provisionally Licensed Mental Health Practitioners: Practitioners who are licensed as a provisional mental health practitioner by the Nebraska Department of Health and Human Services, Division of Public Health or the appropriate licensing agency of the State in which s/he practices.

~~c~~d. Qualified Registered Nurse: A registered nurse (R.N., R.N. with Bachelor's, Masters, or Ph.D., or certification as a psychiatric clinical specialist or nurse practitioner by the American Nurse Association) who is licensed by the Nebraska Department of Health and Human Services, Division of Public Health ~~Regulation and Licensure~~ or the appropriate licensing agency of the state in which s/he practices;

~~d~~e. Qualified Mental Health Professional/Masters Equivalent: A holder of a master's degree in a closely related field that is applicable to the bio/psycho/social sciences or to treatment for persons who are mentally ill and is actively pursuing licensure as a mental health practitioner as allowed by the Nebraska Department of Health and Human Services, Division of Public Health ~~Regulation and Licensure~~; or a Ph.D. candidate who has bypassed the master's degree but has sufficient hours to satisfy a master's degree requirement.

~~4.~~5. Any Medicaid provider who is licensed by the Nebraska Department of Health and Human Services, Division of Public Health ~~Regulation and Licensure~~ and has a substantiated disciplinary action filed against the license that limits the provision of services will not be allowed to provide NMAP services. If a provider is licensed by another state, substantiated disciplinary action filed against that license that limits the provision of services will be cause for termination as an NMAP provider.

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

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

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

Biopsychosocially necessary treatment interventions and supplies are those which are:

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

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

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

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

20-001.16 Active Treatment: Active treatment is provided under an individualized treatment plan developed by the professional staff as required for each level of care. The plan must be based on a face-to-face comprehensive evaluation of the client's restorative needs and potentialities for a primary psychiatric diagnosis. An isolated service, such as a single session with the required professional or a routine laboratory test, not furnished under a planned program of therapy or diagnosis is not active treatment even though the service was therapeutic or diagnostic in nature.

The services must be reasonably expected to improve the client's condition or to determine a psychiatric diagnosis. The treatment must, at a minimum, be designed to reduce or control the client's psychiatric symptoms to facilitate the client's movement to a less restrictive environment within a reasonable period of time.

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

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

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

20-001.17 Treatment Plans: A treatment plan must be established for each client. The treatment plan is a comprehensive plan of care formulated by the clinical staff under the direction of a supervising practitioner and is based on the individual needs of the client. The treatment plan validates the necessity and appropriateness of services and outlines the service delivery needed to meet the identified needs, reduce problem behaviors, and improve overall functioning.

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

The goals and objectives documented on the treatment plan must reflect the recommendations included in the Pre-treatment Assessment and the integration of input from the supervising practitioner and the therapist. The treatment interventions provided must reflect these recommendations, goals, and objectives. Evaluation of the treatment plan by the therapist and the supervising practitioner should reflect the client's response to the treatment interventions based on the recommendations, goals and objectives.

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

The treatment plan must be reviewed and updated by the treatment team according to the client's level of functioning. Minimum time frames for treatment plan reviews are dependent on the type of service. Refer to each individual service description for the review requirements. The purpose of this review is to ensure that services and treatment goals continue to be appropriate to the client's current needs, and to assess the client's progress and continued need for psychiatric services. The supervising practitioner and treatment team members shall sign and date the treatment plan at each treatment plan review.

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

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

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

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

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

Treatment provided to the client must be written legibly or typed in the clinical record in a manner and with a frequency to provide a full picture of the therapies provided, as well as an assessment of the client's reaction to it. If three separate individuals cannot understand the information written in a record because of handwriting that is difficult to read, the program shall provide a readable format. Reimbursement for services may be denied if claims and/or medical records are not legible. Recoupment of previous payments for services may result if appropriate, legible, and complete records are not maintained for the client.

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

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

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

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

20-001.20B Frequency of Inspections: The inspection of care team shall determine, based on the quality of care and services being provided and the condition of clients, at what intervals inspections will be made. However, the inspection of care team 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.

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

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

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

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

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

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

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

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

20-001.20G Reports on Inspections: The inspection of care team 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 facility or through other arrangements, including physician services to clients; and
2. Specific findings about individual clients in the facility.

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

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

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

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

20-001.20J Facility or Provider Response: Within 15 days following the receipt of the inspection of care team's report, the facility shall respond to the review team's coordinator 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;
4. Action to individual client recommendations; and
5. Projected dates of completion on each of the above;

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

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

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

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

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

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

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

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

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

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

The biopsychosocial assessment must be completed by a staff person, acting within his/her scope of practice, who is enrolled as a provider of ~~P~~psychiatric ~~S~~services~~ for Individuals Age 21 and Older~~with the Department. The staff person is responsible for gathering the information included on the assessment through direct face-to-face interview, contact with the family and the comprehensive review of the client's past records. The licensed practitioner of the healing arts who is able to diagnose and treat major mental illness within his/her scope of practice must complete, at a minimum, the Initial Diagnostic Interview within four weeks of the initial session with the therapist. The recommendations must be developed by both practitioners and the practitioners must sign the assessment. Licensed Independent Mental Health Practitioners practicing under their scope of practice must provide both the comprehensive mental health assessment which must include all of the components of the Biopsychosocial assessment and the Initial Diagnostic Interview (see the fee schedule for the appropriate code and modifier). The assessment must include, to the degree deemed clinically appropriate by the qualified mental health professional, but is not limited to the following information:

Biopsychosocial Assessment

1. Presenting Problem and Goals as Described by:
   a. Client;
   b. Family;
   c. Others;
2. Social History:
   a. Environmental influences (moves and reasons, housing conditions);
3. Family Dynamics:
   a. Demographic and historical information;
   b. Divorces, separations, deaths, and incarcerations of parents/ client and significant others (include reasons);
   c. Client and family vocational history;
   d. Client and family treatment history;
4. Mental Health History:
   a. Symptoms;
   b. Diagnoses;
   c. Treatment interventions including psychotropic medications (outcome);
5. Academic, Intellectual, and Vocational History:
   a. Academic history;
   b. Most recent IQ and historical;
   c. Learning disabilities, behavior disorders, or impairment;
   d. Interventions and outcomes;
   e. Vocational history or training;

6. Medical History:
   a. Physical development;
   b. Prenatal, birth, development milestones;
   c. History of injuries and illnesses, handicapping conditions;
   d. Chronic medical conditions and medications taken;
   e. Sexual development, menstrual history, pregnancies, births, or fathered children;
7. Legal History:
   a. Offenses against the client;
   b. History and current legal status;
8. Offender Issues;
   a. Incarceration or probation;
   b. Violence to property;
   c. Violence and assault to others;
   d. Other;
9. Victim Issue:
   a. Physical Abuse;
   b. Sexual Abuse;
   c. Emotional Abuse;
   d. Neglect;
   e. Other;
10. Substance Abuse History;
    a. Client use;
    b. Family history;
    c. Treatment history; and
11. Personal Assets and Liabilities.

<u>Initial Diagnostic Interview</u>

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

Pre-treatment assessments that are incomplete or do not include the initial diagnostic assessment will not be reimbursable.

<u>20-001.22A Involvement of the Supervising Practitioner</u>: The supervising practitioner (see 471 NAC 20-001.13, #1) must meet face to face with the client to complete, at a minimum, the Initial Diagnostic Interview as part of the pre-treatment assessment. The supervising practitioner must work with the staff person to develop the recommendations. The supervising practitioner must sign the assessment document.

20-001.22B Payment for Pre-treatment Assessments: Payment for pre-treatment assessments outlined in the previous section is made according to the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-532). Practitioners shall use the national code sets to bill for pre-treatment assessment functions provided by the clinical staff person and for the Initial Diagnostic Interview provided by the supervising practitioner. The reimbursement for these codes includes interview time, documentation review, and the writing of the report and recommendations.

The assessment must address each area listed in this section to be eligible for reimbursement.

Providers of the pre-treatment assessment shall bill for the entire assessment (Biopsychosocial Assessment and Initial Diagnostic Interview) at one time and on claim form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). The completed Pre-Treatment Assessment must be included in the client file and available for review upon request. Failure to produce a completed pre-treatment assessment upon request, or lack of inclusion in the client file determined during review, shall be cause for claim denial and/or refund.

NMAP will provide reimbursement for one pre-treatment assessment per treatment episode. Addendums may be included if additional information becomes available. If the client remains involved continuously in treatment for more than one year, reimbursement for a pre-treatment assessment will be available annually. If the client leaves treatment prior to a successful discharge and returns for further treatment, the provider must assess the need for an addendum or a new assessment. A second pre-treatment assessment within a year must be prior authorized. Practitioners shall use national code sets to bill for this activity. Prior authorization is obtained through the Medicaid Division or their designee.

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

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

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

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

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

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

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

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

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

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

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

1. A licensed community mental health program which meets the criteria for approval by the Joint Commission on Accreditation of Healthcare Organizations, CARF, COA, or AOA. Certification through the Nebraska Department of Health and Human Services, Division of Public Health ~~Regulation and Licensure~~ will also fulfill compliance with this standard;
2. A licensed and certified hospital which provides psychiatric services and which -
   a. Is maintained for the care and treatment of patients with primary psychiatric disorders;

b. Is licensed or formally approved as a hospital by the Nebraska Department of Health and Human Services, Division of Public Health ~~Regulation and Licensure~~, or if the hospital is located in another state, the officially designated authority for standard - setting in that state;
c. Is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or AOA;
d. Has licensed and certified psychiatric beds;
e. Meets the requirements for participation in Medicare for psychiatric hospitals; and
f. Has in effect a utilization review plan applicable to all Medicaid clients;

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

Therapy is not reimbursable in any other location.

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

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

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

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

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

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

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

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

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

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

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

Supervisory contact may occur in a group setting.

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

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

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

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

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

20-002.05 Pre-Treatment Assessment: Before a client is accepted for treatment, a pre-treatment assessment must be completed (see 471 NAC 20-001.02).

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

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

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

The goals and objectives documented on the treatment plan must reflect the recommendations included in the Pre-treatment Assessment and the integration of input from the supervising practitioner and the therapist. The treatment interventions provided must reflect these recommendations, goals, and objectives. Evaluation of the treatment plan by the therapist and the supervising practitioner should reflect the client's response to the treatment interventions based on the recommendations, goals and objectives.

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

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

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

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

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

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

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

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

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

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

20-002.10 Guidelines for Specific Services

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

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

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

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

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

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

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

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

20-002.10E Professional and Technical Components for Hospital Diagnostic and Therapeutic Services: For regulations regarding professional and technical components for diagnostic and therapeutic hospital services, the elimination of combined billing, and non-physician services and items provided to hospital patients, refer to 471 NAC 10-003.05C, 10-003.05D, 10-003.05E, and 10-003.05F.

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

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

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

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

20-002.11 Payment for Outpatient Psychiatric Services

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

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Medicaid Practitioner Fee Schedule for that date of service. The allowable amount is indicated in the fee schedule as -
   a. The unit value multiplied by the conversion factor;
   b. The maximum allowable dollar amount; or
   c. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established in the fee schedule).

20-002.11B Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to -

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

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

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

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

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

2. Hospitals providing outpatient psychiatric services shall submit all claims for non-physician services on an appropriately completed Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837).

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

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

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

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

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

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

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

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

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

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

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

20-003.01 Covered Day Treatment Services: Psychiatric day treatment programs 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. Providers shall not make any additional charges to the Department or to the client.

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

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

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

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

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

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

Facilities must meet the following standards regarding special treatment procedures:

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

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

20-003.02 Standards for Participation

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

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

   When hospitals provide services in freestanding facilities, the freestanding facility must be appropriately licensed by the Nebraska Department of Health and Human Services, Division of Public Health ~~Regulation and Licensure~~ in accordance with Section 71-2017.01, R.S. Supp., 1981.

20-003.02B Service Standards:

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

7. Pre-Admission Evaluation: The need for this level of care must be recommended on the pre-treatment assessment or addendum. Before the client is admitted to the program, the supervising practitioner shall complete an Initial Diagnostic Interview to validate the appropriateness of care. When a client is transferred from inpatient hospital care to day treatment, the inpatient evaluation and discharge summary documenting the rationale of transfer as part of the treatment plan serves the same purpose as the Initial Diagnostic Interview. The evaluation must be filed in the client's medical record. The pre-admission evaluation must include -
   a. A clinical assessment of the health status and related psychological, medical, social, and educational needs of the client; and
   b. A determination of the range and kind of services required.

   The supervising practitioner shall personally complete an Initial Diagnsotic Interview which must be used to develop the plan of care if all admission criteria have been met;
8. Treatment Plan: The program supervising practitioner shall determine the psychiatric diagnosis and prescribe the treatment, including the modalities and the professional staff to be used. He/she must be responsible and accountable for all evaluations and treatment provided to the client.

   The goals and objectives documented on the treatment plan must reflect the recommendations included in the Pre-treatment Assessment and the integration of input from the supervising practitioner and the therapist. The treatment interventions provided must reflect these recommendations, goals, and objectives. Evaluation of the treatment plan by the therapist and the supervising practitioner should reflect the client's response to the treatment interventions based on the recommendations, goals and objectives.

   The treatment plan shall be completed upon the client's admission to the program;
9. At least every 30 days thereafter, a treatment plan review must be conducted by the multi-disciplinary team, including the supervising practitioner. The treatment plan review must be documented on the Department approved treatment planning document (if required), and in the treatment plan. The facility's treatment plan review format, if approved by the Department, may function as the Department approved treatment planning document.

   The Department approved treatment planning document must be signed by the program supervising practitioner for day treatment services;
10. The supervising practitioner must personally evaluate the client every 30 days, or more often, as medically necessary. This evaluation must occur in a one-to-one, face-to-face session separate from the treatment plan review;

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

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

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

       The provider must document their attempts to involve the family in treatment plan development and treatment plan reviews. A variety of communication means should be considered. These may include, but should not be limited to, including the family via conference telephone calls, using registered letters to notify the family of meetings, and scheduling meetings in the evening and on weekends;
    b. The program must have a description of how the community-based requirement in 471 NAC 20-001 will be met;
    c. The program 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;

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

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

1. Community mental health programs and licensed mental health clinics 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 (FA-20) must also be submitted. The provider application and agreement must be renewed annually to coincide with the submittal of the cost report. Satellites of community mental health programs shall bill the Department through their main community mental health program, unless the satellite has a separate provider number under Medicare. A satellite of a community mental health program that has a separate provider number under Medicare 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 (FA-20) must also be submitted.

20-003.03A Annual Update: The program shall update the provider agreement, program overview, and cost report annually and whenever requested by the Medicaid Division.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Provisions for income tax;
2. Fees paid board of directors;
3. Non-working officers' salaries;
4. Promotion expense, except for promotion and advertising as allowed in HIM-15. Yellow Page display advertising is not allowable; one Yellow Page informational listing is allowable;
5. Travel and entertainment, other than for professional meetings and direct operations of the day treatment program. This may include costs of motor homes, boats, and other recreational vehicles, including operation and maintenance expenses; real property used as vacation facilities; etc.;
6. Donations;
7. Expenses of non-related facilities and operations included in expense;
8. Insurance and/or annuity premiums on the life of officer or owner;
9. Bad debts, charity, and courtesy allowances;
10. Cost and portions of costs which are determined by the Department not to be reasonably related to the efficient production of service because of either the nature or amount of the particular expenditure;
11. Education costs;
12. Services provided by the clients' physicians or dentists, drugs, laboratory services, radiology services, or services provided by similar independent licensed providers, except services provided by state operated facilities. These exclusions are paid separately;
13. Return on equity;
14. Costs for services which occurred in a prior or subsequent fiscal year are unallowable;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Pre-treatment assessment;
2. Supervising practitioner orders;
3. A complete family assessment;
4. Nurses' notes; and
5. Progress notes for all disciplines.

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

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

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

20-003.12 Costs Not Included in the Day Treatment Fee: The mandatory and optional services are considered to be part of the fee for day treatment services. The following charges can be reimbursed separately from the day treatment fee when the services are necessary, part of the client's overall treatment plan, and in compliance with NMAP policy:

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

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

20-004, 20-005 (Reserved)

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

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

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

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

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

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

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

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

1. Hospital Personnel: Hospitals which provide inpatient psychiatric services must be staffed with the number of qualified professional, technical, and supporting personnel, and consultants required to carry out an intensive and comprehensive active treatment program that includes evaluation of individual and family needs; establishment of individual and family treatment goals; and implementation, directly or by arrangement, of a broad-range therapeutic program including, at least, professional psychiatric, medical, surgical, nursing, social work, psychological, and activity therapies required to carry out an individual treatment plan for each patient and their family. The following standards must be met:
   a. Qualified professional and technical personnel must be available to evaluate each patient at the time of admission, including diagnosis of any intercurrent disease. Services necessary for the evaluation include -
      (1) Laboratory, radiological, and other diagnostic tests;
      (2) Obtaining psychosocial data;
      (3) A complete family assessment (see 20-001 and 20-007.07, #7);
      (4) Carrying out psychiatric and psychological evaluations; and
      (5) Completing a physical examination, including a complete neurological examination when indicated, shortly after admission;
   b. The number of qualified professional personnel, including consultants and technical and supporting personnel, must be adequate to ensure representation of the disciplines necessary to establish short-range and long-term goals; and to plan, carry out, and periodically revise a treatment plan for each client based on scientific interpretation of -
      (1) The degree of physical disability and indicated remedial or restorative measures, including nutrition, nursing, physical medicine, and pharmacological therapeutic interventions;
      (2) The degree of psychological impairment and appropriate measures to be taken to relieve treatable distress and to compensate for nonreversible impairments where found;
      (3) The capacity for social interaction, and appropriate nursing measures and milieu therapy to be undertaken, including group living experiences, occupational and recreational therapy, and other prescribed activities to maintain or increase the individual's capacity to manage activities of daily living; and
      (4) The environmental and physical limitations required to protect the client's health and safety with a plan to compensate for these deficiencies and to develop the client's potential for return to his/her own home, a foster home, a skilled nursing facility, a community mental health center, or other alternatives to full-time hospitalization.

2. Director of Inpatient Psychiatric Services and Medical Staff: Inpatient psychiatric services must be under the supervision of a clinical director, service chief, or the equivalent who is qualified to provide the leadership required for an intensive treatment program. The number and qualifications of physicians must be adequate to provide essential psychiatric services. The following standards must be met:
   a. The clinical director, service chief, or equivalent must meet the training and experience requirements for a psychiatrist or a physician for NMAP;
   b. The medical staff must be qualified legally, professionally, and ethically for the positions to which they are appointed; and
   c. The number of physicians must be commensurate with the size and scope of the treatment program.
   d. The physician's personal involvement in all aspects of the client's psychiatric care must be documented in the client's medical record (i.e., physician's orders, progress notes, nurses notes).
   e. The physician must be available, in person or by telephone, to provide assistance and direction as needed.
3. Availability of Physicians and Other Personnel: Physicians and other appropriate professional personnel must be available at all times to provide necessary medical, surgical, diagnostic, and treatment services, including specialized services. If medical, surgical, diagnostic, and treatment services are not available within the hospital, qualified consultants or attending physicians must be immediately available, or a satisfactory arrangement must be established for transferring patients to a general hospital certified for Medicare.
4. Nursing Services: Nursing services must be under the direct supervision of a registered professional nurse who is qualified by education and experience for the position. The number of registered professional nurses, licensed practical nurses, and other nursing personnel must be adequate to formulate and carry out the nursing components of a treatment plan for each client. The following standards must be met:
   a. The registered professional nurse supervising the nursing program must have a master's degree in psychiatric or mental health nursing or its equivalent from a school of nursing accredited by the National League for Nursing, or must be qualified by education or experience in the care of the mentally ill, and have demonstrated competence to -
      (1) Participate in interdisciplinary formulation of treatment plans;
      (2) Give skilled nursing care and therapy; and
      (3) Direct, supervise, and train others who assist in implementing and carrying out the nursing components of each client's treatment plan;

b. The staffing pattern must ensure the availability of a registered professional nurse 24 hours each day for -
   (1) Direct care;
   (2) Supervising care performed by other nursing personnel; and
   (3) Assigning nursing care activities not requiring the services of a professional nurse to other nursing service personnel according to the client's needs and the preparation and competence of the nursing staff available;
c. The number of registered professional nurses, including nurse consultants, must be adequate to formulate a nursing care plan in writing for each client and to ensure that the plan is carried out; and
d. Registered professional nurses and other nursing personnel must be prepared by continuing in-service and staff development programs for active participation in interdisciplinary meetings affecting the planning or implementation of nursing care plans for patients. The meetings include diagnostic conferences, treatment planning sessions, and meetings held to consider alternative facilities and community resources.

5. Psychological Services: The psychological services must be under the supervision of a licensed psychologist. The psychology staff, including consultants, must be adequate in numbers and be qualified to plan and carry out assigned responsibilities. The following standards must be met:
   a. The psychology department or service must be under the supervision of a licensed psychologist;
   b. Psychologists, consultants, and supporting personnel must be adequate in number and be qualified to assist in essential diagnostic formulations, and to participate in -
      (1) Program development and evaluation of program effectiveness;
      (2) Training and research activities;
      (3) Therapeutic interventions, such as milieu, individual, or group therapy; and
      (4) Interdisciplinary conferences and meetings held to establish diagnoses, goals, and treatment programs;
   c. Psychotherapy must be ordered and directed by a physician; and
6. Social Work Services and Staff: Social work services must be under the supervision of a qualified social worker. The social work staff must be adequate in numbers and be qualified to fulfill responsibilities related to the specific needs of individual clients and their families, the development of community resources, and consultation with other staff and community agencies. The following standards must be met:
   a. The director of the social work department or service must have a master's degree from an accredited school of social work and must meet the experience requirements for certification by the Academy of Certified Social Workers and, effective 9-1-94, must be licensed by the Nebraska Department of Health and Human Services, Division of Public Health ~~Regulation and Licensure~~ as a mental health practitioner; and

b. Social work staff, including other social workers, consultants, and other assistants or case aides, must be qualified and numerically adequate to -
   (1) Provide psychosocial data for diagnosis and treatment planning, and for direct therapeutic services to patients, patient groups, or families; to develop community resources, including family or foster care programs; to conduct appropriate social work research and training activities; and to participate in interdisciplinary conferences and meetings concerning diagnostic formulation and treatment planning, including identification and utilization of other facilities and alternative forms of care and treatment.

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

f. The total number of rehabilitation personnel, including consultants, must be sufficient to -
   (1) Permit adequate representation and participation in interdisciplinary conferences and meetings affecting the planning and implementation of activity and rehabilitation programs, including diagnostic conferences; and
   (2) Maintain all daily scheduled and prescribed activities, including maintenance of appropriate progress records for individual clients; and

g. Volunteer service workers must be -
   (1) Under the direction of a paid professional supervisor of volunteers;
   (2) Provided appropriate orientation and training; and
   (3) Available daily in sufficient numbers to assist clients and their families in support of therapeutic activities.

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

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

20-007.04A Professional and Technical Components for Hospital Diagnostic and Therapeutic Services: For regulations regarding professional and technical components for diagnostic and therapeutic hospital services, the elimination of combined billing, and non-physician services and items provided to hospital patients, see 471 NAC 10-003.05C, 10-003.05D, 10-003.05E, and 10-003.05F.

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

1. The patient needs a specific form of psychiatric treatment that can only be provided in the hospital and the structured environment of the hospital is necessary for the client's treatment;
2. Specific observations are needed for evaluation and disposition;
3. Specific observations are needed for following treatment, or control of behavior is necessary for effective somatic therapy or psychotherapy;
4. The client's disorder is a serious threat to his/her adaptation to life and continuing developmental process, and hospitalization at this time is necessary to control this factor;
5. The patient is experiencing psychiatric symptoms, the magnitude of which is not tolerable to self or society and that cannot be alleviated through treatment;
6. The patient is unable to be cared for by self or others, due to psychiatric disorder;
7. All patients must require and receive "active treatment" as defined in 42 CFR 441.154, which is available only in an inpatient setting. Exception: Clients are 65 and older in an IMD (see 471 NAC 20-008); or
8. Ambulatory care services in the community do not meet the treatment needs of the client. Note: In those communities where outpatient resources are not available, the community pattern of referral must be used when appropriate.

20-007.05A Guidelines for Interpretation: Admission of an individual age 21 and older to an acute care facility or an acute level of care may be made only after all resources at a less restrictive level have been explored and deemed inappropriate.

The following will not be accepted as adequate medical indicators for hospital inpatient admission:

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

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

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

*1. Documented evidence of a major psychiatric disorder that necessitates 24-hour medical supervision and daily physician contact.
*2. Documented initial treatment plan with provisions for -
   a. Resolution of acute medical problems;
   b. Evaluation of, and needs assessment for, medications;
   c. Protocol to ensure patient's safety;
   d. Discharge plan initiated at the time of admission.

* Plus one of the following:

3. Demonstrates imminent danger to self or others at the time of admission evidenced by at least one of the following:
   a. Suicide attempt or specific suicide plan with access to means;
   b. Danger to others through a specific action or activity;
   c. Command hallucination with suicidal or homicidal content;
   d. Hallucinations, delusional behavior, or other bizarre psychotic behavior.
4. Presence of other behavior/symptoms to such a degree or in such a combination that acute care is the least restrictive treatment available as demonstrated by at least one of the following:
   a. Physical aggression toward family, peers, or coworkers which could not be considered self protective;
   b. Explosive behavior without provocation or serious loss of impulse control;
   c. Dangerous, assaultive, uncontrolled or extreme impulsive behavior which puts the patient at significant risk, e.g., running into traffic, playing/setting fires, self-abuse, and which cannot be prevented in a non-acute setting;
   d. Severe impairment in concentration and/or hyperactivity;
   e. Behaviors consistent with an acute psychiatric disorder which may include significant mental status changes; and there is documented evidence that no medical condition would account for the symptoms;
5. Severe impairment in psychosocial functioning as demonstrated by at least one of the following:
   a. Psychotic behavior, delusions, paranoia, or hallucinations;
   b. Severe decompensation and interference with baseline functioning;

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

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

20-007.05A2 Acute Services:

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

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

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

* Plus two of the following:

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

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

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

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

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

20-007.07 Documentation in the Client's Clinical Record: The medical records maintained by a hospital permit determination of the degree and intensity of the treatment provided to clients who receive services in the hospital. For inpatient hospital psychiatric services, clinical records must stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the client is hospitalized. The medical record must by legible and include -

1. The identification data, including the client's legal status (i.e., voluntary admission, Board of Mental Health commitment, court mandated);
2. A provisional or admitting diagnosis which is made on every patient at the time of admission and includes the diagnoses of intercurrent diseases as well as the psychiatric diagnoses;
3. The complaint of others regarding the client, as well as the client's comments;
4. The psychiatric evaluation, including a medical history, which contains a record of mental status and notes the onset of illness, the circumstances leading to admission, attitudes, behavior, estimate of intellectual functioning, memory functioning, orientation, and an inventory of the client's strengths in a descriptive, not interpretative, fashion;
5. A complete neurological examination, when indicated, recorded at the time of the admitting physical examination;
6. A social history sufficient to provide data on the client's relevant past history, present situation, social support system, community resource contacts, and other information relevant to good treatment and discharge planning;
7. A family assessment as described in 471 NAC 20-001;
8. Reports of consultations, psychological evaluations, electroencephalograms, dental records, and special studies;
9. The client's treatment plan and treatment plan reviews;
10. The treatment received by the client, which is documented in a manner and with a frequency to ensure that all active therapeutic efforts, such as individual, group, and family psychotherapy, drug therapy, milieu therapy, occupational therapy, recreational therapy, nursing care, and other therapeutic interventions, are included;
11. Progress notes which are recorded by the psychiatrist or physician, nurse, social worker, and, when appropriate, others significantly involved in active treatment modalities. The frequency is determined by the condition of the client, but progress notes must be recorded daily by nursing staff, and at each contact by psychiatrist or physician and by all other therapeutic staff (such as O.T., R.T.). Progress notes must contain a concise assessment of the client's progress and recommendations for revising the treatment plan as indicated by the client's condition;

12. The psychiatric diagnosis contained in the final diagnosis written in the terminology of the current American Psychiatric Association's Diagnostic and Statistical Manual;
13. Therapeutic leave days prescribed by the psychiatrist under the treatment plan. The client's response to time spent outside the hospital must be entered in the client's hospital clinical record;
14. Transition and discharge planning documentation;
15. Proof of family and community involvement;
16. A copy of the MC-14 certification; and
17. The discharge summary, including a recapitulation of the client's hospitalization, recommendations for appropriate services concerning follow-up, and a brief summary of the client's condition on discharge.

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

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

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

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

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

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

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

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

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

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

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

20-007.13 Form Completion: Inpatient hospital psychiatric service providers shall -

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

Payment for approved services is made to the hospital.

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

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

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

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

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

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

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

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

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

20-008.03A Provider Agreement: The provider 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.

20-008.03B 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. This information must be submitted with a new copy of Form MC-20.