Mental Health, Substance Use Disorder, and Applied Behavior Analysis Services

Definitions:

Adult Services: Services provided to individuals 21 years of age or older*

ABA: Applied Behavior Analysis

ABA Assessment: An assessment to determine the need for Applied Behavior Analysis treatment, identify initial intervention targets and establish a treatment baseline, as defined in the definition in this manual titled *Applied Behavior Analysis Behavior Identification Assessment*

Annually: Per state fiscal year (July 1 – June 30th)

ASD: Autism Spectrum Disorder

Caregiver: A family member, friend or neighbor who provides unpaid assistance to a Medicaid recipient

Collateral Contact: Contacts which occur outside the provider organization without the beneficiary present and are related to the beneficiary's individual treatment, rehabilitation, and recovery plan

Continually Engaged in Treatment: Continuous engagement in mental health or substance use disorder treatment is defined as an individual who has ongoing participation in treatment and has attended appointments consistently (at least one appointment per month) without a break of more than 3 calendar months in the past 12 months.

Daily: Once per 24-hour period between 12:00 am and 11:59 pm

Dual Diagnosis: The condition of having a diagnosis of both a mental health disorder and a substance use disorder at the same time

EPSDT: Early and Periodic Screening, Diagnostic and Treatment

IDD: Intellectual or Developmental Disability

In-Person: A visit in which the provider is in the same physical space as the member while services are provided

Published: November 20, 2026
Effective date: February 1, 2027

Institution for Mental Disease (IMD). An institution for mental disease (IMD) is defined as an entity with more than 16 beds that primarily provides inpatient or residential treatment for beneficiaries with mental diseases, according to federal regulations

Licensed Clinicians: Individuals who hold an active license to practice medicine, nursing, psychology, applied behavior analysis, mental health or substance use disorder treatment. Licensed clinicians must meet the qualifications outlined in this document. Licensed clinicians must operate within their professional competencies, including documented training or experience in applied behavior analysis, or mental health or substance use disorder treatment as appropriate. Licensed clinicians may only include:

- Psychiatrist
- Physician
- Psychologist
- Provisionally licensed psychologist
- Advanced practice registered nurse (APRN)
- Physician Assistant (PA)
- Licensed Independent Mental Health Practitioner (LIMHP)
- Licensed Mental Health Practitioner (LMHP)
- Provisionally Licensed Mental Health Practitioner (PLMHP)

If providing treatment for substance use disorders only, licensed clinicians may also include:

- Licensed alcohol and drug counselor (LADC)
- Provisionally licensed alcohol and drug counselor (PLADC)

If providing treatment for applied behavior analysis only, licensed clinicians may also include:

- Licensed Behavior Analyst (LBA)
- Licensed assistant Behavior Analyst (LaBA)

Medical Necessity: mental health, substance use disorder, and applied behavior analysis services must be provided in accordance with the medical necessity guidelines outlined in 471 NAC 1-002.02A

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

Non-Licensed Staff: Individuals who do not hold an active license to practice medicine, psychology, nursing, mental health or substance use disorder treatment

Hospital Outpatient: An outpatient is defined as a person who has not been admitted as an inpatient but is registered on the hospital records as an outpatient and receives services, rather than supplies alone

Professional Competencies: Knowledge, skills, and abilities that enable licensed clinicians and unlicensed staff to provide effective, ethical, and skillful care in a specialized area of care, such as substance use treatment. Providers must be able to demonstrate professional competency through documentation of education or experience in a subject area

Supervision: Supervision by the supervising practitioner is defined as the critical oversight of a treatment activity or course of action that is intended to ensure quality care and promote professional development of the supervised practitioner

Serious Mental Illness (SMI): Individuals with serious mental illness are defined as individuals that meet the following criteria:

1. A Diagnostic and Statistical Manual of Mental Disorders (DSM) (current edition) diagnosis consistent with a long standing serious and persistent mental illness with symptoms of sufficient severity and duration that it is expected to cause significant, ongoing, disabling functional impairments. These impairments are beyond the scope of the person's informal support system to remediate and require professional assistance to guide the individual to recovery
2. Persistent mental illness as demonstrated by the presence of the disorder for the last 12 months or which is expected to last 12 months or longer and will result in a degree of limitation that seriously interferes with the individual's ability to function independently in an appropriate manner in two of three functional areas:
    a. Activities of Daily Living: Inability to consistently perform the range of practical daily living tasks for basic adult functioning in three of five of the following:
        i. Grooming, hygiene, washing clothes, meeting nutritional needs
        ii. Care of personal business affairs
        iii. Transportation and care of residence
        iv. Procurement of medical, legal, and housing services, or
        v. Recognition and avoidance of common dangers or hazards to self and possessions
    b. Vocational/Education:
        i. Inability to be employed or an ability to be employed only with extensive supports

ii. Deterioration or decompensation resulting in inability to establish or pursue educational goals within normal time frame or without extensive supports, or
iii. Inability to consistently and independently carry out home management tasks

c. Social skills:
   i. Repeated inappropriate or inadequate social behavior or ability to behave appropriately only with extensive supports
   ii. Consistent participation in adult activities only with extensive supports or when involvement is mostly limited to special activities established for persons with mental illness, or
   iii. History of dangerousness to self/others

Upon Admission: Immediately as an individual is admitted to the facility

Week: A period of seven days, beginning on Sunday and continuing through the following Saturday

Youth Services: Services provided to individuals 20 years of age or younger*

*Nebraska covers all medically necessary services needed to correct and ameliorate health conditions for EPSDT youth age 20 and younger, regardless of the age of service noted in this manual. Requirements for coverage of EPSDT services are outlined in NAC 471, chapter 33: Health Check (Early Periodic Screening, Diagnosis and Treatment [EPSDT] Services) and the EPSDT section of this manual.

General Provider Requirements

To participate in Nebraska Medicaid, providers of mental health, substance use, and applied behavior analysis services must comply with all applicable provider participation requirements codified in Title 471 Nebraska Administrative Code (NAC) 2 and 3. In the event provider participation requirements in Title 471 NAC 2 or 3 conflict with requirements outlined in 471 NAC 20, 32, or 35 the individual provider participation requirements in 471 NAC 20, 32, or 35 will govern.

For requirements for participation for the DHHS Division of Behavioral Health, please refer to the Division of Behavioral Health Provider Manual.

Enrollment

All licensed and non-licensed individuals providing mental health, substance use disorder, or applied behavior analysis services must be enrolled with Nebraska Medicaid.

Providers who are located in a state other than Nebraska must also be enrolled with Medicaid in the state where they are located.

Medicare Enrollment:

Nebraska Medicaid encourages all applicable providers to enroll with Medicare as it is expected that the billing provider is enrolled with both programs.

Medicare is the primary payer for services rendered to dual-eligible members. Once the claim is billed to Medicare, Nebraska Medicaid will act as the secondary payer and provide coverage according to coordination of benefits policy 471 NAC 3 section 005.

Provider Certification and Accreditation

Mental Health Substance Abuse Treatment Centers (MHSATCs) must be licensed by the DHHS Division of Public Health and accredited by the commission on accreditation of rehabilitation facilities (CARF), the joint commission (TJC), or the council on accreditation (COA), and accredited to provide the level of care applicable to the services they provide as required by DHHS Division of Medicaid and Long-Term Care (MLTC) and the DHHS Division of Behavioral Health.

Out-of-state providers must meet licensure and certification requirements of that state, and must be enrolled as an approved provider with that state's Medicaid agency.

Accreditation

Providers who are enrolled with Medicaid as one of the following provider enrollment types must be licensed by the DHHS Division of Public Health and accredited by TJC or AoA and must be accredited to provide the level of care applicable to this service as required by DHHS Division of Medicaid and Long-Term Care (MLTC):

- Hospital
- Hospital Clinic

Providers who are enrolled with Medicaid as one of the following provider enrollment types must be accredited by CARF, TJC, or COA, and accredited to provide the level of care applicable to the services they provide as required by DHHS Division of Medicaid and Long-Term Care (MLTC) and the DHHS Division of Behavioral Health:

- Professional Clinic
- Assertive Community Treatment
- Community Support

Licensure Requirements

All providers subject to licensure must be appropriately licensed by the DHHS Division of Public Health as required by DHHS Division of Medicaid and Long-Term Care (MLTC) and the DHHS Division of Behavioral Health, and must maintain current licensure.

All providers subject to certification must be appropriately certified by the DHHS Division of Public Health, the DHHS Division of Behavioral Health, or the appropriate certifying entity, and must maintain current certification.

All providers billing Medicaid services must ensure that their staff meet the requirements outlined in this document.

All licensed and non-licensed staff providing mental health, substance use disorder, or applied behavior analysis services must:

1. Work within their scope of practice to provide treatment
2. Have documented training in rehabilitation, recovery principles and trauma informed care
3. Have documented training in cultural competence

If providing treatment for individuals diagnosed with substance use disorder:

4. Have documented training in the biopsychosocial dimensions of substance use disorder

Supervision Requirements

Supervision is a process in which the supervisor participates with supervisees to ensure quality of clinical care and professional development. Supervision is not a billable service for mental health and substance use disorder services. For Applied Behavior Analysis, supervision during direct patient care in accordance with ABA billing guidelines may be a billable service, and must follow the requirements described in the Applied Behavior Analysis definition in this manual.

All licensed and non-licensed staff who are not eligible to practice independently under Nebraska state law must be supervised. The supervising provider must be:

1. Currently licensed and eligible to practice independently under Nebraska state law
2. Currently enrolled with Nebraska Medicaid and eligible to provide Medicaid services
3. Eligible to provide supervision to the supervisee under Nebraska state law and this document
4. Within their professional competencies to prescribe and oversee the service being provided

Supervision entails:

1. Oversight of treatment activity and course of action
2. Review of each individual's treatment plan and progress notes
3. Individual-specific case discussion
4. Periodic assessments of the individual
5. Diagnosis, treatment intervention or issue-specific discussion

Involvement of the supervisor, when applicable, must be reflected in the Initial Diagnostic Interview, the treatment plan and the documentation of interventions provided.

Supervision of Initial Diagnostic Interviews

Licensed and provisionally licensed clinicians who are eligible to complete IDIs in consultation with an independently licensed clinician include:

- Licensed mental health practitioner (LMHP)
- Provisionally licensed mental health practitioner (PLMHP)
- Provisionally licensed psychologist
- Specially licensed psychologist

The consulting clinician must be one of the following:

- Physician
- Psychologist
- Licensed Independent Mental Health Practitioner

When an IDI is performed by a clinician listed above, the following requirements must be met in order to bill for the Initial Diagnostic Interview:

- The IDI must be performed in consultation with an independently licensed clinician, who functions as a consultant clinician in accordance with the requirements outlined in this document, and the requirements of the DHHS Division of Public Health, Licensure Unit
- The consultant clinician must be licensed in Nebraska and enrolled with Nebraska Medicaid
- The consultant clinician must be immediately available to furnish assistance and direction, either face to face or via telehealth and show evidence of supervision by signing the IDI.
- The clinician who is performing the IDI must be able to demonstrate one of the following:
    - That they are an employee of the consultant clinician
    - That they are an employee of the legal entity that employs the consultant clinician
    - That they have a formal, documented supervision arrangement with the consultant clinician

Medical and Clinical Directors

Medical directors and clinical directors take clinical responsibility for care provided, and are essential elements to ensure program fidelity and accordance with national best practices. Medical and clinical directors are expected to be in-person at each program to provide medical and clinical oversight. Medical and clinical director requirements are outlined for each service with requirements specific to the focus area and acuity of the program.

Medical and Clinical Directors in mental health or substance use treatment centers must have experience and education in the treatment of mental health disorders, substance use disorders, or both, as appropriate to the treatment provided by the facility. Clinical directors in programs working with ASD or IDD treatment must have experience and education in the treatment of ASD or IDD, or both.

Clinical Directors must provide consultation and support to all program staff and the individuals served and are responsible for all clinical decisions. The Clinical Director must

continually incorporate new clinical information into the program to assure program effectiveness and viability, ensure accurate organization and management of clinical records, and other program documentation.

Medical Director Requirements

Medical Directors must be able to dedicate sufficient daily and weekly time to the program to ensure medical oversight. Depending on the size of the program, they may also serve as the clinical director.

Geographically Deprived Areas:

A geographically deprived area is an area where a medical director with the appropriate specialization for the program is not available in the community, or within a reasonable driving distance of the community, to provide services. For mental health programs, this includes board-certified psychiatrists or psychiatric APRNs. For substance use programs, this includes physicians or APRNs with board certification in addiction medicine or equivalent substance use related board certification.

In geographically deprived areas, a physician or APRN who is qualified, skilled, and experienced in the diagnosis and treatment of substance use or mental health disorders, as appropriate to the program, may serve as an alternative. A resume detailing the physician or APRN's mental health or substance use disorder education and experience must be submitted to and approved by Nebraska Medicaid prior to beginning medical director duties. The physician or APRN is subject to all policy requirements outlined for psychiatrists and APRNs, respectively. Services and oversight provided by the physician or APRN must not exceed six months without documented consultation between the physician or APRN providing the service and a psychiatrist, psychiatric RN, or physician or APRN with board certification in addiction medicine or equivalent, as appropriate to the service.

Request for telehealth exceptions to Medical Director requirements:

If a residential or inpatient treatment program cannot identify an in-person medical director who meets the requirements outlined in this manual, exceptions to allow a medical director to provide services via telehealth must be requested through the Division of Medicaid and Long-Term Care (MLTC) and approved by the director. Exceptions will be filed with the department and must be renewed yearly.

To request an exemption, the provider must provide:

- The reason for requesting the exemption

- Documentation showing that the requested telehealth provider meets the requirements for the position as outlined in this manual
- A copy of a formal contract with the requested telehealth provider, including requirements that the provider dedicate sufficient daily and weekly time to the program to ensure medical and clinical oversight, and that they can be present in-person at the physical location of services at least 2 times per calendar year.
- A copy of a formal contract with an MD or APRN who is located within 30 minutes of the physical location where services are provided who will respond in-person in the case of medical emergencies or urgent clinical need
- Documentation that there is sufficient medical staff available on-site (RN or LPN) to ensure safety and medical oversight of the program

Program Staffing and Ratios

For all services, providers must have sufficient staff on-site or on-call during their hours of operation (24/7 in residential and inpatient programs) to maintain integrity of care for the range and severity of problems that may be addressed within the service. Providers must meet required staffing ratios as outlined in each service definitions, determine the level of staffing needed to safely operate the program, and follow requirements from the DHHS Division of Public Health as applicable. Staffing ratios are listed for each service in the "staffing ratio" section of the service description.

Specific Provider Requirements

Licensed Clinicians

All licensed clinicians must have current licensure in Nebraska and be enrolled with Nebraska Medicaid.

Advanced practice registered nurse (APRN)

Supervision required: no supervision required after completion of a transition-to-practice agreement as required by Nebraska state law

	Minimum Requirements:
All Services	Psychiatric experience

Anesthesiologist

Supervision required: No

	Minimum Requirements:
All Services	Must be licensed as an MD, DO, or CRNA

Licensed alcohol and drug counselor (LADC)

Supervision required: No

	Minimum Requirements:
All Services	• May provide services for substance use disorders only • Dual licensure as an LMHP or LIMHP is preferred
Youth Services	• Equivalent of one year of full-time work experience or graduate studies in direct child or adolescent services, ASD or IDD services

Provisionally licensed alcohol and drug counselor (PLADC)

Supervision required: Must be supervised by a Physician, Psychologist, or LADC

	Minimum Requirements:
All Services	• May provide services for substance use disorders only • Dual licensure as an LMHP or LIMHP is preferred
Youth Services	• Equivalent of one year of full-time work experience or graduate studies in direct child or adolescent services, ASD or IDD services

Licensed behavior analyst (LBA)

Supervision required: No

	Minimum Requirements:
All services	No additional requirements beyond licensure

Licensed assistant behavior analyst (LaBA)

Supervision required: Must be supervised by an LBA

	Minimum Requirements:
All Services	No additional requirements beyond licensure

Licensed independent mental health practitioner (LIMHP)

Supervision required: No

	Minimum Requirements:
All Services	If providing treatment for individuals diagnosed with substance use disorder, dual licensure as an LADC is preferred
Youth Services	Equivalent of one year of full-time work experience or graduate studies in direct child or adolescent services, ASD or IDD services

Licensed mental health practitioner (LMHP)

Supervision required: No

	Minimum Requirements:
All Services	If providing treatment for individuals diagnosed with substance use disorder, dual licensure as an LADC is preferred
Youth Services	Equivalent of one year of full-time work experience or graduate studies in direct child or adolescent services, ASD or IDD services

Provisionally licensed mental health practitioner (PLMHP)

Supervision required: Must be supervised by a Physician, Psychologist, LIMHP, or LMHP

	Minimum Requirements:
All Services	If providing treatment for individuals diagnosed with substance use disorder, dual licensure as an LADC is preferred
Youth Services	Equivalent of one year of full-time work experience or graduate studies in direct child or adolescent services, ASD or IDD services

Licensed practical nurse (LPN)

Supervision required: Must be supervised by a Physician, APRN, or RN

	Minimum Requirements:
All Services	Experience or education in the treatment of mental health disorders preferred

Physician (MD or DO)

Supervision required: No

	Minimum Requirements:
All Services	Board certified or board eligible psychiatrist preferred
ABA Assessment	Must have specific training and expertise in Applied Behavior Analysis

Physician assistant (PA)

Supervision required: Must be supervised by a Physician

	Minimum Requirements:
All Services	Experience or education in the treatment of mental health disorders preferred

Psychologist

Supervision required: No

	Minimum Requirements:
All Services	No requirements beyond licensure
ABA Assessment	Must have specific training and expertise in Applied Behavior Analysis

Provisionally licensed psychologist:

Supervision required: Must be supervised by a psychologist

	Minimum Requirements:
All Services	One year of supervised professional experience

Psychologist associate, psychologist assistant, specially licensed psychologist

Supervision required: Must be supervised by a psychologist

	Minimum Requirements:
All Services	Must be registered with the Nebraska Department of Health and Human Services, Division of Public Health

Specially licensed psychologist

Supervision required: Must be supervised by a psychologist

	Minimum Requirements:
All Services	No requirements beyond licensure

Psychiatrist

Supervision required: No

	Minimum Requirements:
All Services	Physician (MD or DO) who is a board certified or board eligible psychiatrist
ABA Assessment	Must have specific training and expertise in Applied Behavior Analysis

Registered nurse (RN)

Supervision required: No

	Minimum Requirements:
All Services	Experience or education in the treatment of mental health disorders preferred

NON-LICENSED STAFF

Registered behavior technician (RBT)

Supervision required: Must be supervised by an LBA or a Psychologist with training in ABA

	Minimum Requirements:
All Services	• Current certification as a Registered Behavior Technician by the Behavior Analyst Certification Board.

Certified peer support provider

Supervision required: Must be supervised by a Physician, Psychologist, APRN, PA, LIMHP, or LMHP. May be supervised by a LADC if providing substance use services only

	Minimum Requirements:

All Services	• High school diploma or equivalent and one of the following:
	  ○ Two years of coursework in a human service field, or
	  ○ Two years of work experience in a human service field, or
	  ○ Combination of work experience and education in a human service field, with one year of education substituting for one year of experience, or
	  ○ Two years of lived recovery experience with demonstrated skills in treatment of individuals with a behavioral health diagnosis
	• Complete a Nebraska training program, with 60 hours or more training, and pass the certification exam to obtain Nebraska certification as a Certified Peer Support provider
	• Maintain Nebraska certification by completing continuing education requirements as identified by the certifying organization. The supervising practitioner assumes professional responsibility for the services provided by the Certified Peer Support provider

Community support worker

Supervision required: Must be supervised by a Physician, Psychologist, APRN, PA, LIMHP, or LMHP. May be supervised by a LADC if providing substance use services only

	Minimum Requirements:
All Services	• High school diploma or equivalent and one of the following: ○ Two years of coursework in a human service field, or ○ Two years of work experience in a human service field, or ○ Combination of work experience and education in a human service field, with one year of education substituting for one year of experience, or ○ Two years of lived recovery experience with demonstrated skills in treatment of individuals with a behavioral health diagnosis

Direct care staff

Supervision required: Must be supervised by a Physician, Psychologist, APRN, PA, LIMHP, or LMHP. May be supervised by a LADC if providing substance use services only

	Minimum Requirements:
All Services	• High school diploma or equivalent and one of the following: ○ Two years of coursework in a human service field, or ○ Two years of work experience in a human service field, or ○ Combination of work experience and education in a human service field, with one year of education substituting for one year of experience, or ○ Two years of lived recovery experience with demonstrated skills in treatment of individuals with a behavioral health diagnosis

General Service Requirements

All providers of services described in this document are subject to the following requirements:

Crisis Assistance

Crisis assistance must be available to all individuals served 24 hours a day, 7 days a week. If a provider is not able to provide access to 24/7 crisis services, they may refer individuals to telephonic, text, and chat crisis intervention call centers that meet 988 Suicide & Crisis Lifeline standards for risk assessment and engagement of individuals at imminent risk of suicide. The resources provided and a plan for access must be included in the individual's Individualized Treatment, Rehabilitation and Recovery Plan.

Provider Competencies and Trauma-Informed Care

All services must be trauma-informed, and providers should have training and competencies in effectively delivering services that meet the social, developmental, cultural, and linguistic needs of patients. Staff should receive appropriate training and demonstrate the ability to effectively interact with people across different cultures and backgrounds.

Treatment environments and procedures should be adjusted and adapted to account for individual's symptoms or sensory sensitivities as needed, such as lighting, sound, and touch preferences.

Documentation

All documents submitted to Nebraska Medicaid must contain sufficient information for identification on the member and provider. Additional documentation from the clinical record may be requested prior to considering authorization of payment so that determination of medical necessity or indication of active treatment can be objectively verified.

The beneficiary's clinical record must include:

Assessments and Diagnosis

Copies of all required assessment reports that have been completed with documentation of the individual's diagnosis, rationale for that diagnosis, and intervention recommendations.

Assessments must contain timely information on patient diagnosis and symptoms in order to recommend the appropriate level of care for the individual, including clinical justification and criteria. To ensure that treatment is based on accurate and timely information, patients should be reassessed regularly via treatment plan reviews and periodic repeated assessments and assessment addendums to track progress and determine any diagnostic changes. Reassessment also informs treatment plan reviews and guides updates to the treatment plan. Treatment plan review and reassessments should be used along with continued stay and discharge criteria to determine whether an individual needs treatment at a more or less intensive level of care, or whether continued treatment at their current level of care is appropriate.

For individuals receiving treatment for substance use disorders, level of care assessments should be administered and regularly updated to identify treatment needs across all appropriate ASAM dimensions.

Coordination of Care

The clinical record must contain documentation verifying any coordination with other treating providers, including when more than one provider is involved with the individual and family, or when referrals are made to other providers for medical, psychological, and psychopharmacology needs.

Discharge Planning and Transition Plans

Discharge planning should begin at the onset of treatment and is an ongoing process that occurs through the duration of service. The transition plan must be strengths-based, person-centered, recovery-oriented, and trauma-informed. The discharge plan must be documented in the individual's record. The discharge plan must:

- Begin on admission and be updated on an ongoing basis with the direct and active participation of the individual, as well as family, guardians, or other supports, as authorized by the individual.
- Be a component of the Individualized Treatment, Rehabilitation, and Recovery plan and be consistent with the goals and objectives identified with the direct and active participation of the individual, family, or legal guardian as appropriate and authorized by the individual

Transition plan

The transition plan must be developed with the input of the individual, and must include family, guardians, or other supports, if appropriate and authorized by the individual. If the individual is unable to participate in the development of the plan (e.g. due to administrative discharge), the lack of participation and reason must be included in the transition plan documentation. The individual's involvement with discharge planning should be appropriate to their age and ability, and providers may need to adapt their communication strategies to meet the individual's needs, including visual aids, clear and concise language, or alternative communication methods for those with speech and language difficulties.

The transition plan must be documented in the individual's clinical record and contain the signature of the staff who wrote the plan, and the supervising clinician and date of signatures. The transition plan must:

1. Be provided within the time frame specified in the program's policies and procedures which considers the prompt transfer of clinical records and information to ensure continuity of care
2. Provide a narrative summary of service provided
3. Document the individual's progress in relation to the individual's treatment, rehabilitation, and recovery plan, addressing recovery-oriented goals identified by the individual and how strengths have been utilized
4. Describe the reason(s) for discharge
5. Document referral information, and
6. Include recommendations and/or arrangements not limited to:
    a. Any ongoing treatment and rehabilitative service needs
    b. Accessing and using medication
    c. Accessing physical health care
    d. Employment
    e. Transportation
7. Be made available to Nebraska Medicaid or delegate as requested in order to facilitate case management and coordination of care.

Family and Community Involvement

The individual's family, guardians, or other supports must be offered the opportunity to participate in the individual's treatment (assessment, treatment and recovery planning, psychotherapy and discharge planning), if appropriate and authorized by the individual.

This participation or lack of participation must be documented in the individual 's clinical record.

Progress notes

Each clinical record must contain a chronological record of all mental health, substance use disorder, or applied behavior analysis services provided to the individual, the date performed, the duration of the session (including session start and end times), and the staff member who conducted the session. Progress notes must document implementation of the individual's treatment, rehabilitation, and recovery plan. Progress notes must be completed within the time frame specified in the program's policies and procedures and document the unit(s) provided to the individual. Progress notes must:

- Include the date, place, and modality of the services (e.g. in-person, telehealth).
- Substantiate each service provided through narrative description, including a summary of activities and interventions delivered during the service
- Include an accurate start and end time for the service
- Indicate how services provided relate specifically to goals and priorities identified in the individual's treatment, rehabilitation, and recovery plan
- Document the individual's participation in the service, and revision of goals and treatment activities as needed
- Periodically, the progress note should document collaborative review of progress measures and their patterns over time, directly with individuals to ensure care remains aligned with their goals, supports shared decision-making, and promotes meaningful progress toward improved well-being. These periodic measures of person-focused progress tracking should be standardized reports of symptom burden and/or functional status from the individual or their guardian.

Medications

A chronological account of any medications prescribed, the name, dosage, and frequency to be administered and individual's response

Treatment Planning

Initial treatment plan

The initial treatment plan is an individualized, preliminary plan that addresses the short-term goals the program plans to achieve during the period from admission to completion of the Individualized Treatment, Rehabilitation, and Recovery Plan. The initial treatment plan shall be in effect until the Individualized Treatment, Rehabilitation, and Recovery Plan has been developed. If an initial diagnostic

interview or substance use disorder assessment has been completed within three months prior to admission, and is determined to be relevant to the service provided by the admitting clinician, the recommendations from these assessments may serve as the initial treatment plan.

Individualized Treatment, Rehabilitation, and Recovery Plan

The Individualized Treatment, Rehabilitation, and Recovery Plan must be developed with the individual and must include family, guardians, and other supports as appropriate and authorized by the individual. Each record must contain an individualized treatment, rehabilitation, and recovery plan that is recovery-oriented for all services provided based on the individualized and person-centered assessment of the individual and the requirements of this manual.

Treatment plan recommendations must be in accordance with the results of diagnostic interviews, testing and assessments performed. Regular, thorough reviews of the individual's progress, including documentation of progress and revision of goals as needed must occur on a regular schedule, as outlined in each service-specific definition in this manual. These reviews do not require a full reassessment of an individual and must occur regardless of insurance authorization period.

The individual's involvement with treatment planning should be appropriate to their age and ability, and providers may need to adapt their communication strategies to meet the individual's needs, including visual aids, clear and concise language, or alternative communication methods for those with speech and language difficulties.

This plan must:

1. Be oriented to and apply the principles of recovery including but not limited to inclusion, direct and active participation, and a meaningful life in the community of one's choosing
2. Incorporate and be consistent with best practices
3. Include the individual's individualized goals and expected outcomes in their own words if possible
4. Contain prioritized objectives that are measurable and time-limited
5. Describe therapeutic interventions that are trauma-informed, person-centered, strength-based, and recovery-oriented
6. Identify staff responsible for implementing the therapeutic interventions
7. Specify the planned amount, frequency, and duration of each therapeutic intervention
8. Delineate the specific criteria to be met for discharge or transition to a lower level of care

9. Include a component to avoid crises or admission to a higher level of care using principles of recovery and wellness, including 24/7 crisis resources
10. Document that the individual treatment, rehabilitation, and recovery plan is completed within the time frame specified in Nebraska Medicaid regulations and this manual
11. Document that the plan has been developed, reviewed, updated, and revised with the direct and active involvement of the individual and their parents or guardians, as appropriate and authorized by the individual. If documentation shows that the individual is not achieving their goals, timely revision of the plan must be documented
12. Include the signature of the individual or guardian, or both, to indicate agreement with the plan. If the individual served is under the age of 18, the plan must be signed by a parent or guardian
13. Be approved and signed by the licensed clinician or supervisor if provisionally licensed

Medication Management and Administration

Medication management:

Medication management includes the prescribing and monitoring of medications, and is not required unless indicated in the definition in this manual for the service being provided. If medication management is listed as a required component of the service, it must follow the guidelines outlined in the medication management definition in this manual and may not be reimbursed separately.

Medication administration:

Medications must be administered under the supervision of an RN, or an LPN under RN supervision. Staff without a medical or nursing license who administer medications must hold a current Medication Aide certification from the DHHS Division of Public Health.

Nursing assessment and Physical Examination

Nursing assessments are not required unless indicated in the definition in this manual for the service being provided. If required, a nursing assessment must include the following elements and must be documented in the individual's clinical record and contain the signature of the nurse and date of signature.

Nursing Admission Assessment Summary

1. Past medical and psychiatric history: Prior hospitalizations, major illnesses, and surgeries
2. Assess pain: Location, severity, and use of a pain scale
3. Allergies: Medications, foods, and environmental; nature of the reaction and seriousness; intolerances to medications
4. Medications: Confirm accuracy of the list, names, and dosages of medications include supplements and over-the-counter medications
5. Activities: Check functional abilities (ADLs) and need for assistive equipment.
6. Falls and general risk assessment
7. Psychosocial: Identify any signs of agitation, restlessness, hallucinations, depression, suicidal ideations, or substance use- may require a more focused assessment
8. Nutrition: Appetite, changes in body weight, any nutritional needs
9. Vital signs: Temperature, heart rate, respiratory rate, blood pressure, pain level on admission, oxygen saturation
10. Any handoff information from other departments or agencies

Physical Examination

11. Cardiovascular: Heart sounds; pulse regularity, presence of swelling, edema, or cyanosis
12. Respiratory: Breath sounds, breathing pattern, cough, dyspnea on exertion
13. Gastrointestinal: Bowel sounds, abdominal tenderness, any masses, bowel movements, nausea, vomiting, abdominal pain
14. Genitourinary: Identify any voiding issues, for females any menstrual issues (if applicable)
15. Neuromuscular: Level of consciousness; speech clarity; pupil reactivity and appearance; extremity movement equal or unequal; steady gait; trouble swallowing
16. Integument: general skin condition, any signs of skin breakdown, acute or chronic wounds

"Providing Access"

Providers must facilitate access to outside treatment, include Medication Assisted Treatment (MAT) and physical examinations. This should not be interpreted to mean that every provider must offer MAT and physical examination. Providing access means investigating whether the individual has a need for the service or is already participating in the service (in the case of MAT), and ensuring that the individual can access that service.

MAT: Providers must not deny admission to an individual due to participation in MAT services. Residential providers should assist with arranging transportation to MAT appointments while the individual is participating in the program.

Physical examinations: Providers should ask individuals about their physical health and whether they have had a recent examination. If the individual reports that they have not had an exam in the past 12 months, providers should assist the individual with accessing physical health care services.

The extent of the assistance provided may vary as appropriate to the service – e.g. outpatient therapists may provide resources, providers of case management or residential services should assist with identifying a provider, scheduling the appointment, and identifying or providing transportation. Where more extensive involvement is required, it is specified in the service requirements. Providers should collaborate with the individual to identify the amount of assistance needed based on the individual's skill and severity of need.

Individuals may refuse to provide information on MAT or physical examinations or may refuse to allow a provider to assist with access. In these cases, the provider should document the attempt and refusal.

Psychoeducational groups

Psychoeducational groups are informative sessions led by licensed clinicians, nurses, or direct care staff operating within their professional competencies that promote knowledge, skill development, and support in an interactive group setting. Psychoeducational groups must provide education, skill development, or support that is relevant to the individual's diagnoses and symptoms, and oriented towards one of the following areas:

- Mental health or substance use disorder diagnoses and symptoms
- Mental health or substance use disorder treatment strategies
- Crisis intervention planning
- Positive coping strategies and symptom management
- Wellness and recovery tools
- Self-help or support groups
- Substance use education
- Community resources and navigation
- Family dynamics and healthy relationships
- Positive leisure and recreational activities
- Vocational or educational resources
- Social skills and healthy communication
- Physical health and nutrition
- Independent living skills
- Medication education

Psychoeducational groups must be provided under the supervision of a licensed clinician. Groups must be face-to-face, and may be provided by licensed clinicians, nurses (RN or LPN under RN supervision), or direct care staff as appropriate to their education, experience, and professional competencies. Medication education, if provided, must be provided by a pharmacist, physician, APRN, RN, or LPN under RN supervision.

Psychotherapy Treatment Models

All psychotherapy treatments and interventions must identify a specific model and process and document reasonable fidelity to the validated process related to that model of psychotherapy.

Play, art, or music therapy or eye movement desensitization and reprocessing (EMDR) may be provided when determined by a licensed practitioner to be clinically appropriate based on their professional competencies and medical necessity for the individual. Play, art, or music therapy or EMDR may be incorporated as part of individual, family, or group psychotherapy sessions as a complementary element to other treatment models used

during psychotherapy services. These treatment models may not be used as the sole model of treatment for an individual.

Providers of play, art, or music therapy or EMDR must be able to demonstrate upon request that they have documented training and competence in the chosen treatment model.

Setting

Allowable settings for services are outlined by category as defined below. The exact determination is based on the appropriateness of the environment and the services provided.

Institutions for Mental Disease (IMDs): Medicaid does not reimburse for services provided in IMDs except as outlined in Nebraska Administrative Code Title 471, Chapters 20, 32, and 35.

Definitions:

Home: Location, other than a hospital or other facility, where the patient receives care in a private residence.

- **Nursing facilities (NFs) and Assisted living facilities (ALFs):** services allowed in a home setting may be provided in an ALF or NF if the individual meets admission criteria for the service, unless the requirements in this manual specify they are disallowed in an ALF or NF setting

Hospital: An inpatient facility which provides medical and psychiatric services by, or under, the supervision of physicians

Community: A location other than a home that is not part of a hospital or residential treatment facility that is appropriate for the provision of outpatient services. Appropriateness should be determined by the treating clinician and include assessment of safety and access to privacy

Limitations: The following settings qualify as a community location only if they meet the criteria outlined below:

- **School**: Services allowed in a community setting may be provided in a school if they are non-duplicative of school services, and the requirements within this manual do not specify that they are disallowed in a school setting. Medicaid does not reimburse providers for educational services, or services that are the legal responsibility of school districts

- **Outpatient services provided by a hospital:** Hospitals billing outpatient psychiatry and psychology services must follow CMS coding guidelines for psychiatry and psychology services

Facility: A non-hospital facility that is not a skilled nursing facility which provides treatment to live-in residents who do not require acute medical care

Office or Clinic: A location that provides mental or physical health care on an outpatient basis. Includes services provided by an outpatient-only clinic that is part of a hospital.

Support Services

Providers are expected to assess individual's needs for housing support and community resources, and refer to external supports as appropriate. The intensity of assistance varies by the level of service and is indicated in the Support Services section of each service definition. Individuals should be assessed at intake for housing and vocational needs, and these needs should be addressed at discharge.

Telehealth

Services which may be provided by telehealth are indicated on the Mental Health and Substance Use fee schedule. If a service is listed in the Mental Health and Substance Use fee schedule with telehealth modifier 93 or 95, then the service may be completed via telehealth if the following criteria are met:

- Telehealth is provided in alignment with the requirements outlined in Nebraska Administrative Code Title 471, Chapter 47
- There is clinical documentation that the use of telehealth will adequately meet the needs of the individual as determined by the clinician
- The reason for the use of telehealth is documented and appropriate for the service. Lack of transportation, distance, and other barriers that affect access to services are an allowable reason for the use of telehealth
- Telehealth is not used solely for the convenience of the provider or the individual or caregivers or guardians
- There are documented plans in place to keep the individual's environment safe
- There are documented plans in place to ensure protection of patient privacy
- The individual or their caregiver or guardian have regular access to technology and a secure internet connection
- There are documented plans in place for access to in-person services in cases of crisis, or if telehealth is no longer meeting the needs of the individual

- Telehealth services are performed within ethical guidelines for each provider's professional competencies and license

If the fee schedule does not indicate a telehealth modifier for a service code, then the service is not allowed via telehealth.

Service Specific Requirements

Crisis Services

Crisis Psychotherapy

Outpatient crisis psychotherapy for mental health, substance use, or co-occurring disorders may be provided to adults, youth, or families. Crisis psychotherapy is an immediate, short-term treatment provided to an individual who is in acute distress and under complex or life-threatening circumstances that demand immediate attention.

Crisis psychotherapy may be provided as an active intervention to an individual who is experiencing a crisis in the community. Licensed clinicians work to collaboratively decrease emotional distress and reduce the risk of danger and harm to people who are experiencing a mental health or substance use crisis, in order to avoid unnecessary emergency department (ED) care, psychiatric inpatient hospitalizations, and law enforcement involvement through community-based crisis care, referrals, and care coordination.

SERVICE CATEGORY	Mental health or substance use disorder, or both
ALLOWABLE SETTINGS	May be provided in the following settings: • Community • Home • Office or Clinic
BILLING INFORMATION	Fee schedule codes for this service are: • **90839 - Crisis Psychotherapy (1st hour)** • **90840 - Crisis Psychotherapy (additional 30 min)** **Telehealth:** Mobile crisis: initial response is conducted in person. Responses may be via telehealth if in-person response is not possible. If telehealth is used, the reason for the use of telehealth rather than in-person response must be documented. Responses may be in collaboration with law enforcement; follow-up may occur in person, telephonically, or virtually
ADMISSION CRITERIA	• Age: Any • The individual demonstrates symptomatology consistent with a diagnosis as outlined in the current editions of the Diagnostic and

	Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association • Symptoms negatively impact the individual's ability to function successfully in home, community or school settings. Symptoms are typically life threatening or complex and indicate high levels of distress
SERVICE REQUIREMENTS	**Assessments** • Conduct a risk assessment including screening tools such as SBQR, ASQ, CAGE-AID, CSSRS to ensure the individual is assessed for suicidality, homicidality, substance use disorder, and current symptoms. The assessment must be sufficient to determine the appropriate interventions for the individual, and to evaluate whether the individual can be managed safely at this level of care **Clinical Services** • Utilize the Stanley-Brown Safety Planning Intervention with the individual and support system, or other validated approach such as Collaborative Assessment and Management of Suicidality (CAMS) • Provide mental health or substance use disorder interventions and crisis management • Ensure consultation with hospital emergency personnel, law enforcement, and community agencies as needed • Initiate emergency services or transportation to a higher level of care in cases of imminent safety concerns, if the clinician identifies that the individual cannot be safely supported with this level of care • Arrange for alternatives to psychiatric hospitalization if appropriate • Services must be trauma informed and sensitive to potential personal safety risks such as suicidal intention • Provide in-person, telephonic, or virtual post-crisis follow-up support with the first attempt made within 24 hours and 3 total attempts made within 72 hours or sooner if clinically indicated or requested • All providers must complete training in overdose prevention and administration of opioid overdose reversal medications • Overdose reversal medications must be available when the clinician is providing services in person **Support Services** • The licensed clinician must coordinate care with the individual's primary medical, primary psychiatric and established behavioral health provider, if applicable • The crisis outpatient psychotherapy provider should provide referrals and care coordination to link individuals with mental health, substance use, and economic assistance providers as appropriate, including referrals to higher levels of care as clinically indicated. • Provide warm hand-offs to referrals when possible

	• Coordinate transportation for the individual to facilitate crisis stabilization, when needed
LENGTH OF SERVICE	Services continue until the crisis is resolved or the risk is decreased, and the individual is connected to ongoing mental health or substance use disorder treatment as needed.
STAFFING REQUIREMENTS	Psychotherapy services must be provided by licensed clinicians as defined in this document, operating within their professional competencies. All clinicians must be trained in recognizing the symptoms of an opioid overdose and administering overdose reversal medications, such as naloxone.
STAFFING RATIO	1 Licensed clinician: 1 Individual
HOURS OF OPERATION	The provider should have the capacity to respond to unscheduled crisis contacts 24 hours a day, 7 days a week.
CONTINUED STAY REQUIREMENTS	• Crisis Outpatient Psychotherapy is limited to five sessions per episode of crisis. If the individual needs continued care after 5 sessions, an IDI should be completed and the individual should be referred or transitioned to the appropriate level of care. • Transfer to a more intensive level of care is indicated when the individual's signs or symptoms have failed to respond to treatment and have intensified
DESIRED INDIVIDUAL OUTCOME	• The individual's mental health or substance use crisis has resolved, and the individual is able to remain stable in the community • Services to ensure the individual's ongoing safety and the prevention of recurrent crisis are in place • Post-crisis follow up has been completed

Crisis Stabilization

Crisis Treatment and Stabilization services provide a safe, facility-based treatment and stabilization to individuals in crisis. The facility provides continuous 24 hours a day, 7 days a week observation and supervision for individuals who do not require intensive treatment in an inpatient psychiatric setting and would benefit from emergency services

The primary objective of Crisis Treatment and Stabilization is to resolve the crisis, stabilize and restore the individual to a level of functioning that requires a less restrictive level of care, and to facilitate the individual's connection to and engagement in the appropriate level of mental health or substance use treatment.

SERVICE CATEGORY	Mental health or substance use disorder, or both
ALLOWABLE SETTINGS	• Facility • Hospital • **Emergency Department*** ***This service may be provided in an emergency department (ED) if the ED has a designated mental health stabilization unit that meets all of the requirements of this definition.**
BILLING INFORMATION	Fee schedule codes for this service are: • • S9484 - Crisis Intervention Residential Stabilization (per hour) • S9485 - Crisis Intervention Residential Stabilization (per diem) S9484: use for stays of 1 hour or more, up to 23 hours and 59 minutes S9485: use when an individual stays for 24 or more hours Telehealth: This service must be provided in person.
ADMISSION CRITERIA	• Age: Any • The individual demonstrates symptomatology consistent with a diagnosis as outlined in the current editions of the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association • Individual demonstrates a significant incapacitating or debilitating disturbance in mood or thought interfering to the extent that immediate treatment and stabilization is required

	• Clinical evaluation of the individual's condition indicates dramatic and sudden decompensation with a potential for danger to self or others and the individual lacks supports or resources to ensure safety • Individual requires 24 hours observation and supervision but not the intensive treatment in an inpatient psychiatric setting • A less intensive or restrictive level of care has been considered or tried, or clinical evaluation indicates the onset of a life-endangering psychiatric condition, but there is insufficient information to determine the appropriate level of care

SERVICE REQUIREMENTS	**Assessments**
	• Conduct a risk assessment including screening tools such as SBQR, ASQ, CAGE-AID, CSSRS to ensure the individual is assessed for suicidality, homicidality, substance use disorder, and current symptoms. The assessment must be sufficient to determine the appropriate level of care in which the individual should be placed, and to evaluate whether the individual can be managed safely at this level of care
	• A nursing assessment by an RN, or LPN under RN supervision, must be completed upon admission
	  ○ If recommended by the RN or LPN, a physical exam must be completed by a physician, physician assistant (PA), or APRN upon admission. If medical staff are not immediately available, the individual must be transferred to a medically monitored inpatient withdrawal management program or an emergency medicine facility as clinically indicated.
	  ○ If the nursing assessment or physical examination determine that the individual cannot be safely managed by the program due to acute intoxication or withdrawal symptoms or medical needs, they must be transferred to a medically monitored withdrawal management program or an emergency medicine facility as clinically indicated.
	• If the individual remains in treatment for over 48 hours, an Initial Diagnostic Interview (IDI) must be completed. The IDI must meet the requirements as noted in the Initial Diagnostic Interview definition in this manual
	  ○ If an IDI was completed within the previous 12 months of admission to the service, and is determined to be clinically relevant, it can serve as the IDI. If there is new information available, including changes in the treatment, recovery, and rehabilitation plan, an update to the IDI must be documented in the form of an IDI addendum. The IDI addendum must reflect the individual's current functional status
	
	Treatment Planning
	• An initial treatment plan must be developed upon admission. The plan must incorporate a stabilization plan which includes:

	○ Crisis stabilization ○ Relapse prevention ○ Care management ○ Medication management ○ Mobilization of family support and community resources ○ Referrals to consultants for any medical, psychiatric, psychopharmacology and psychological needs as needed • Review and update the initial treatment plan daily. Review must be completed under the supervision of a licensed clinician with the individual • All efforts to engage the individual in development of the individual's initial treatment plan must be made. If the individual is not capable of participating in treatment plan development due to significant mental health or substance use symptoms, the reason for their lack of involvement must be documented **Medical and Withdrawal Services** • The program must provide access to supervised withdrawal services, on-site if available or via a formal transfer agreement with a provider of supervised detoxification services (formerly social detox/ASAM 3.2). Services must meet the requirements of the Supervised Detoxification definition in this manual. Individuals may not be enrolled in both services simultaneously. **Clinical Services** • The program must have nursing staff on-site 24 hours a day, 7 days a week • Daily assessment of progress by a licensed clinician. The initial treatment plan must be updated based on this assessment • An RN, or LPN under RN supervision, must monitor self-administered medications • Clinical monitoring of stabilization as indicated in the initial treatment plan, including monitoring for changes that may require medical consultation or transition of care • The medical director or a psychiatrist or APRN must be available in person or via telehealth 24 hours a day, 7 days a week • Psychotherapy must be offered daily, and a minimum of one session must be completed prior to discharge. Individuals may refuse, or may be excused from psychosocial services if warranted due to medical symptoms or severity of mental health or substance use symptoms. Refusal or inability to attend due to symptoms must be documented, including the reason for non-attendance. **Support Services** • Provide access to Medication Assisted Treatment (MAT) as medically appropriate

	• Consultation, referral, or both for medical, psychological, and psychopharmacology needs
	• Assist the individual with accessing community supports and resources. The program must provide the following assistance as appropriate:
	  ○ Coordinate with community resources on behalf of the individual
	  ○ Assist with healthcare navigation
	  ○ Coordinate with the individual's other treating providers
	  ○ Assist individuals with application for and access to benefits and social support services
	  ○ Assist individuals with reintegration into the community by identifying and connecting individuals with off-site vocational, educational, and rehabilitative resources
	
	Discharge Planning
	• Discharge planning is an ongoing process that occurs through the duration of service. A documented discharge plan must be completed upon admission as part of the initial treatment, recovery, and rehabilitation plan
	• A transition plan must be completed prior to discharge. A copy of the transition plan must be given to the individual and to providers at the individual's next level of care, as applicable
	• The program must assist individuals with transition and discharge planning. The program must provide the following assistance as appropriate:
	  ○ Assist individuals with identifying and accessing housing resources
	  ○ Coordinate with community resources on behalf of individuals to facilitate successful reintegration into daily activity such as work, school, or family living
	  ○ Provide referrals and coordinate transition to a lower or higher level of care as clinically indicated

LENGTH OF SERVICE	• Services continue for up to 5 days or until the crisis is resolved or the risk is decreased, or • The individual's symptoms have failed to respond to treatment or have intensified, such that a transfer to a more intensive level of care is indicated Stays greater than 5 days may be requested in certain clinical circumstances for which clinical justification must be submitted for prior authorization and be approved.
STAFFING REQUIREMENTS	**Medical Director** Must have 2 years of experience in mental health disorder treatment Must be one of the following:

	• Psychiatrist • Physician • Advanced Practice Registered Nurse (APRN) A consulting psychiatrist must be available, if not in the Medical Director position **Clinical Director** Must be one of the following: • Psychiatrist • Physician • Psychologist • Advanced practice registered nurse (APRN) • Registered Nurse (RN) • Physician Assistant (PA) • Licensed independent mental health practitioner (LIMHP) **Licensed Clinicians** A licensed clinician must be available on call 24 hours a day, 7 days a week **Licensed Nursing staff** Must include at least one of the following: • Licensed Registered Nurse (RN) • Licensed Practical Nurse (LPN) **Direct Care staff** Sufficient to meet staffing ratio **Optional staff may include:** Certified Peer Support Providers Peer support services, if provided by the program, are included in program reimbursement and may not be separately reimbursed **Additional Requirements** All program staff must be trained in crisis de-escalation and intervention through a nationally accredited training program. All program staff must complete training in overdose prevention and administration of opioid overdose reversal medications. The program must maintain an overdose response protocol and have a formal relationship with an emergency medicine provider. Overdose reversal medications must be available at the facility at all times.

STAFFING RATIO	Licensed clinicians to individuals during day hours: 1:8 Licensed nursing staff: minimum of 1 on-site 24/7 Direct care staff to individual: 1:10 Minimum of two awake staff during night hours A licensed clinician must be available on-call 24 hours a day
HOURS OF OPERATION	24 hours a day, 7 days a week
CONTINUED STAY REQUIREMENTS	All of the following criteria must be met for continuing treatment at this level of care: • The acuity of the individual's symptoms continues to necessitate treatment at the current level of care based on admission criteria • The individual does not require a more intensive level of services and no less intensive level of care is appropriate • The individual's treatment plan is up to date, with targets that are appropriate and related to improvement in the individual's symptoms and achievement of their goals. • The individual is making progress towards rehabilitation goals and they are showing progress towards symptom reduction as demonstrated by objective behavioral measurement of functional improvement or standardized report from the member or guardian of symptom and/or functional improvement. • If progress has not been made or symptoms are increased, the treatment plan has been modified to focus on any new symptoms or to address barriers to progress. • There is evidence that the treatment team is working towards a transition plan to meet the individual's treatment needs once this level of care is no longer appropriate.
DESIRED INDIVIDUAL OUTCOME	• Symptoms are stabilized and the individual no longer meets clinical criteria for admission or continued stay • The individual has substantially recovered their level of functioning • The individual meets the initial treatment plan goals and objectives including successful stabilization of mental health or substance use disorder symptoms • The individual is referred to ongoing treatment and recovery services • The individual has support systems in place to help the individual maintain stability in the community

Emergency Psychiatric Observation

Emergency Psychiatric Observation provides up to 23 hours and 59 minutes of care in a secure, medically supervised hospital setting for evaluation and stabilization of acute mental health symptoms. Observation status is commonly assigned to individuals who present to the emergency department and who then require a significant period of treatment or monitoring before a decision is made concerning their admission or discharge.

The service must provide evaluation and treatment to prevent further exacerbation or deterioration and inpatient hospitalization when possible and facilitate transition to the appropriate level of care.

SERVICE CATEGORY	Mental health or substance use disorder, or both
ALLOWABLE SETTINGS	• Hospital
BILLING INFORMATION	Fee schedule codes for this service are: • 99221 - Initial Inpatient Hospital Care E/M Services, Low Medical Decision Making • 99222 - Initial Inpatient Hospital Care E/M Services, Moderate Medical Decision Making • 99223 - Initial Inpatient Hospital Care E/M Services, High Medical Decision Making • 99231 - Subsequent Inpatient Hospital Care E/M Services, Low Medical Decision Making • 99232 - Subsequent Inpatient Hospital Care E/M Services, Moderate Medical Decision Making • 99233 - Subsequent Inpatient Hospital Care E/M Services, High Medical Decision Making *Please refer to CPT guidelines for coding observation visits for details on how to code this service.* **Telehealth** This service must be provided in person.
ADMISSION CRITERIA	• Age: any • The individual presents with symptoms consistent with a psychiatric crisis that requires a period of medical observation • The individual's medical needs are stable • The individual does not meet all inpatient level of care criteria

	• There is a lack of diagnostic clarity and further evaluation is necessary to determine the individual's service needs

SERVICE REQUIREMENTS	**Assessments**
	• Conduct a risk assessment including brief mental health status and substance use disorder screening tools such as SBQR, ASQ, CAGE-AID, CSSRS to ensure the individual is assessed for suicidality, homicidality, substance use disorder, and current symptoms. The assessment must be sufficient to determine the appropriate level of care in which the individual should be placed, and to evaluate whether the individual can be managed safely at this level of care
	• A nursing assessment by an RN, or LPN under RN supervision, must be completed upon admission
	
	Treatment Planning
	• A crisis stabilization plan must be developed upon admission, and must include plans for:
	  ○ Crisis stabilization
	  ○ Relapse prevention
	  ○ Care management
	  ○ Medication management as applicable
	  ○ Mobilization of family support and community resources
	  ○ Referrals to consultants for any medical, psychiatric, psychopharmacology and psychological needs as needed
	
	Clinical Services
	• The program must have nursing staff on-site 24 hours a day, 7 days a week
	• Continuous assessment of the need for continued care, or determination that the crisis has resolved and the individual can safely return to the community with follow-up services
	• Medication management must be provided as clinically indicated
	• Clinical monitoring of stabilization as indicated in the crisis stabilization plan, including monitoring for changes that may require medical consultation or transition of care
	• A consulting psychiatrist must be available in person or via telehealth 24 hours a day, 7 days a week.
	
	Support Services
	• Provide access to Medication Assisted Treatment (MAT) as medically appropriate
	• The program must coordinate care with the individual's primary care provider and psychotherapy provider, if applicable
	• Consultation, referral, or both for medical, psychological, and psychopharmacology needs
	• Assist the individual with accessing community supports and

	resources. The program must provide the following assistance as appropriate: ○ Coordinate with community resources on behalf of the individual ○ Assist with healthcare navigation ○ Coordinate with the individual's other treating providers **Discharge Planning** • Discharge planning is an ongoing process that occurs through the duration of service. A documented discharge plan must be completed upon admission as part of the initial treatment, recovery, and rehabilitation plan • A transition plan must be completed prior to discharge. A copy of the transition plan must be given to the individual and to providers at the individual's next level of care, as applicable • Provide referrals and coordinate transition to a lower or higher level of care as clinically indicated
LENGTH OF SERVICE	• Services continue for up to 23 hours and 59 minutes or until the crisis is resolved or the risk is decreased, and the individual is transferred to an appropriate level of care for continued behavioral health treatment, or • The individual's symptoms have failed to respond to treatment or have intensified, such that a transfer to a more intensive level of care is indicated • If an individual receives 24 or more hours of continuous care, that individual is defined as an inpatient regardless of the hour of admission, whether they used a bed, and whether they remained in the hospital past midnight or the census-taking hour
STAFFING REQUIREMENTS	**Medical Director** Must have 2 years of experience in mental health disorder treatment Must be one of the following: • Psychiatrist • Physician • Advanced Practice Registered Nurse (APRN) A consulting psychiatrist must be available, if not in the Medical Director position **Licensed Clinicians** A licensed clinician must be available on call 24 hours a day, 7 days a week **Licensed Nursing staff** Must include at least one of the following: • Licensed Registered Nurse (RN) • Licensed Practical Nurse (LPN)

	All program staff must complete training in overdose prevention and administration of opioid overdose reversal medications. The program must maintain an overdose response protocol Overdose reversal medications must be available at the facility at all times.
STAFFING RATIO	All positions must be staffed in sufficient numbers to meet hospital accreditation guidelines A licensed clinician must be available on-call 24 hours a day
HOURS OF OPERATION	24 hours a day, 7 days a week
CONTINUED STAY REQUIREMENTS	• If it is determined that continued care is needed beyond the 24-hour period, the individual must be transferred to inpatient hospitalization or an alternative level of care
DESIRED INDIVIDUAL OUTCOME	• Symptoms are stabilized and the individual no longer meets clinical criteria for admission • Individual has substantially recovered their level of functioning • The individual is referred to ongoing mental health treatment services • Sufficient supports are in place and individual can safely return to a less restrictive environment

Supervised Detoxification (Social Detox)

Supervised Detoxification provides supervised intervention in substance use disorder emergencies on a 24 hour per day basis to individuals experiencing acute intoxication or withdrawal. This service has the capacity to provide a safe, medically supervised setting with staff present for, observation and implementation of a withdrawal plan to physiologically restore the individual from an acute state of intoxication

SERVICE CATEGORY	Substance use disorder
SETTING	Adult Substance Use Disorder (SUD) Supervised Detoxification services are provided in the following setting: • Facility
BILLING INFORMATION	Fee schedule code for this service is: • H0012 Adult Substance Use Disorder Supervised Detoxification (per hour) • H0013 Adult Substance Use Disorder Supervised Detoxification (per diem) H0012: use for stays of 1 hour or more, up to 23 hours and 59 minutes H0013: use when an individual stays for 24 or more hours Provider types which are allowed to bill for these services are outlined in the Mental Health and Substance Use Fee Schedule. **Telehealth** This service must be provided in person.
ADMISSION REQUIREMENTS	• Age: 21 years of age or older – for youth eligibility, refer to EPSDT requirements as outlined in the definition section of this manual. • In order to meet criteria for this level of care, the individual must meet all of the following criteria: ○ The individual is experiencing mild-to-moderate symptoms of withdrawal. Biomedical conditions and complications: none or mild ○ Emotional, behavioral or cognitive conditions and complications – None to Mild severity; need structure to focus on recovery ○ Substance Use-Related Risks: The patient has a high likelihood of risky substance use and engaging in high-risk substance use behaviors. ○ Recovery environment: The individual's recovery environment is not supportive of detoxification or entry into treatment, the

	individual's current environment is unsafe, or the individual is unable to function in their current environment. There are barriers to care, a need for motivational enhancement, or concerns with the individuals' social determinants of health. ○ The individual needs supervision in order to manage withdrawal safely, but does not meet ASAM criteria for admission to a level 3.7 Medically Monitored Inpatient Withdrawal program ○ This level of care is the best treatment option with expectation of improvement in the individual's behavioral functioning ○ This level of care is the least restrictive setting that will produce the desired results in accordance with the needs of the individual
SERVICE EXPECTATIONS	**Assessments** • A nursing assessment by an RN, or LPN under RN supervision, must be completed at the time of admission. The assessment must be sufficient to determine the appropriate level of care in which the individual should be placed, and to evaluate whether the individual can be managed safely at this level of care. The evaluation should include recommendations for further in-depth physical examination as indicated ○ If recommended by the RN or LPN, a physical exam must be completed by a physician, physician assistant (PA), or APRN upon admission. If medical staff are not immediately available, the individual must be transferred to a medically monitored inpatient withdrawal management program or an emergency medicine facility as clinically indicated. ○ If the nursing assessment or physical examination determine that the individual cannot be safely managed by the program due to acute intoxication or withdrawal symptoms or medical needs, they must be transferred to a medically monitored withdrawal management program or an emergency medicine facility as clinically indicated. The program must have a formal transfer agreement with an ASAM level 3.7 MMIW program or emergency medicine facility • If the individual remains in treatment for over 48 hours, a substance use disorder (SUD) assessment must be completed. The SUD assessment must meet the requirements outlined in the SUD Assessment definition in this manual ○ If an SUD assessment was completed within 12 months prior to admission to the service, and is determined to be clinically relevant, it can serve as the SUD assessment. If there has been a gap in treatment of six months or more, or if there is new information available, an SUD addendum must be completed and may serve as the SUD assessment.

	○ If the Medical Director, RN, or LPN under RN supervision determines that the individual is not capable of completing the substance use disorder assessment due to significant medical or withdrawal symptoms, the substance use disorder assessment and history may be deferred. The individual must be reassessed to determine if they are capable of completing the assessment after an additional 24 hours if the individual remains in treatment. The reason for deferment must be documented. **Treatment Planning** • An initial treatment plan must be developed upon admission • Review and update the initial treatment plan daily. Review must be completed under the supervision of a licensed clinician with the individual • All efforts to engage the individual in development of the individual's initial treatment plan must be made. If the individual is not capable of participating in treatment plan development due to significant withdrawal symptoms, the reason for their lack of involvement must be documented **Clinical Services** • Hourly monitoring during acute withdrawal phase • The program must have nursing staff on-site 24 hours a day, 7 days a week • A withdrawal plan must be developed by a physician or APRN within 24 hours of admission. The withdrawal plan must include frequency of monitoring of withdrawal symptoms, seizure risk protocols, and monitoring other co-occurring symptoms • Daily in-person assessment of progress through withdrawal by an RN or LPN under RN supervision. The withdrawal plan must be updated based on this assessment • An RN, or LPN under RN supervision, must monitor self-administered medications • Clinical monitoring of withdrawal using a standardized withdrawal scale (CIWA/COWS) as indicated in the withdrawal plan, including monitoring for changes that may require medical consultation or transition of care • A physician or APRN with the professional competencies to manage withdrawal and co-occurring medical conditions, must be available in person or via telehealth 24 hours a day, 7 days a week. The physician or APRN must have controlled substance prescribing authority, including buprenorphine and Flumazenil • Offer daily psychoeducational groups for a minimum of 2 hours per day. The amount, frequency, and intensity of services must be appropriate to individual needs and level of function as determined by

clinical assessment. Individuals may be excused from psychosocial services if warranted due to medical symptoms or severity of withdrawal symptoms
- Overdose reversal medications must be available at the facility at all times

Support Services

- Provide access to Medication Assisted Treatment (MAT) as medically appropriate
- Consultation, referral, or both for medical, psychological, and psychopharmacology needs
- Assist the individual with accessing community supports and resources. The program must provide the following assistance as appropriate:
    - Coordinate with community resources on behalf of the individual
    - Assist with healthcare navigation
    - Coordinate with the individual's other treating providers
    - Assist individuals with application for and access to benefits and social support services
    - Assist individuals with reintegration into the community by identifying and connecting individuals with off-site vocational, educational, and rehabilitative resources

Discharge Planning

- Discharge planning is an ongoing process that occurs through the duration of service. A documented discharge plan must be completed upon admission as part of the initial treatment, recovery, and rehabilitation plan
- A transition plan must be completed prior to discharge. A copy of the transition plan must be given to the individual and to providers at the individual's next level of care, as applicable
- The program must assist individuals with transition and discharge planning. The program must provide the following assistance as appropriate:
    - Assist individuals with identifying and accessing housing resources
    - Coordinate with community resources on behalf of individuals to facilitate successful reintegration into daily activity such as work, school, or family living
    - Provide referrals and coordinate transition to the appropriate level of care as clinically indicated

LENGTH OF SERVICE	• Services continue for up to 5 days or until withdrawal signs and symptoms are sufficiently resolved that the individual no longer meets continued stay criteria at this level of care, or • The individual's signs or symptoms of withdrawal have failed to respond to treatment or have intensified, such that a transfer to a more intensive level of care is indicated Stays greater than 5 days may be requested in certain clinical circumstances for which clinical justification must be submitted for prior authorization and be approved.
STAFFING	**Medical Oversight** *May be part-time or contracted. Must be available on-site or on-call during admission hours* Must be one of the following: • Psychiatrist • Physician • Advanced practice registered nurse (APRN) **Clinical Director** Must be one of the following: • Psychiatrist • Physician • Psychologist • Advanced practice registered nurse (APRN) • Registered Nurse (RN) • Physician Assistant (PA) • Licensed independent mental health practitioner (LIMHP) • Licensed mental health practitioner (LMHP) • Licensed alcohol and drug counselor (LADC) **Licensed Clinicians**: Sufficient to meet staffing ratio **Licensed Nursing staff:** Must be on-site 24/7 Must include at least one of the following: • Licensed Registered Nurse (RN) • Licensed Practical Nurse (LPN) **Direct Care staff**: Sufficient to meet staffing ratio **Additional Requirements** All program staff must complete training in overdose prevention and administration of buprenorphine and opioid overdose reversal medications. The program must maintain an overdose response protocol and have a formal relationship with an emergency medicine provider.

STAFFING RATIO	Licensed clinicians to individuals during day hours 1:10 Direct care staff to individual 1:10 Minimum of two awake staff during night hours A licensed clinician must be available on-call 24 hours a day
HOURS OF OPERATION	24 hours a day, 7 days a week
CONTINUED STAY REQUIREMENTS	All of the following criteria must be met for continuing treatment at this level of care: • The acuity of the individual's symptoms continues to necessitate treatment at the current level of care based on admission criteria • The individual does not require a more intensive level of services and no less intensive level of care is appropriate • The individual's treatment plan is up to date, with targets that are appropriate and related to improvement in the individual's symptoms and achievement of their goals. • The individual is making progress towards rehabilitation goals and they are showing progress towards symptom reduction as demonstrated by objective behavioral measurement of functional improvement or standardized report from the member or guardian of symptom and/or functional improvement. • If progress has not been made or symptoms are increased, the treatment plan has been modified to focus on any new symptoms or to address barriers to progress. • There is evidence that the treatment team is working towards a transition plan to meet the individual's treatment needs once this level of care is no longer appropriate.
DESIRED INDIVIDUAL OUTCOME	• Symptoms are stabilized and the individual no longer meets clinical criteria for admission or continued stay • The individual has substantially recovered their level of functioning • The individual meets the initial treatment plan goals and objectives including successful detoxification and stabilization of withdrawal symptoms • The individual is referred to ongoing withdrawal treatment and recovery services • The individual has support systems in place to help the individual maintain stability in the community

Therapeutic Family Care

Therapeutic Family Care (TFC) provides support to youth who are in the higher tiers of foster care and are in need of additional crisis services. TFC provides care coordination and crisis behavioral health services to help these youth to remain in the community and prevent more restrictive, facility care.

Crisis Support Services for Therapeutic Family Care (TFC) are:

1. Crisis Service Maintenance and Response (TFC CSMR) that provides 24 hours a day, seven days a week triage and intervention, and at least monthly outreach if needed, and
2. Community-based Mobile Crisis response if indicated, with follow-up until risk is lowered and/or the individual is connected to the necessary behavioral health services.

Crisis Support Services - TFC are home and community-based services provided by Medicaid-enrolled providers working in collaboration with the DHHS Division of Children and Family Services (DCFS). **Providers must be approved by DCFS and must be able to provide both services in order to enroll.**

Therapeutic Family Care Crisis Service Maintenance and Response (TFC CSMR)

TFC CSMR must provide a phone line that is answered by a live voice 24 hours a day, 7 days a week and can link the individual enrolled in the TFC Program to a licensed behavioral health professional, law enforcement, and other emergency services. This phone line is called the TFC 24-Hour Crisis Support phone line.

TFC CSMR is designed to assist individuals enrolled in the TFC Program and their foster parents (TFC foster family) in pre-crisis or crisis situations related to a behavioral health problem. The desired outcome is de-escalation of the pre-crisis or crisis, ensuring safety and making the necessary linkages.

SERVICE CATEGORY	Mental health or substance use disorder
SETTING	Phone
BILLING INFORMATION	Fee schedule code for this service is: • H0030 Crisis Services Maintenance and Response (per day) (Crisis Support Service TFC)

	Only approved, enrolled Therapeutic Family Care (TFC) providers may bill for these services. **Telehealth** This service is provided via telehealth.
ADMISSION REQUIREMENTS	The individual must meet the Therapeutic Family Care eligibility criteria and meet all the following Admission Requirements: • Verbal report of a current behavioral health pre-crisis or crisis • Verbal request for assistance with the pre-crisis or crisis
SERVICE EXPECTATIONS	**Assessments** • Perform brief screening of the intensity of the situation. **Clinical Services** • Provide a phone line that is answered by a live voice 24 hours a day, 7 days a week and called the TFC 24-Hour Crisis Support phone line • A protocol is in place to ensure the caller is connected to a clinician in real-time through a "warm hand-off" when deemed necessary. The protocol must include an on-call clinician who is expected to immediately answer calls, a back-up clinician in the event the on-call clinician is non-responsive, and a hand-off to 988 in the event the back-up clinician is non-responsive • Work with the TFC foster family unit toward immediate relief of distress in pre-crisis and crisis situations; reduction of the risk of escalation of a crisis; arrangements for emergency onsite responses when necessary; and referral to appropriate services when other or additional intervention is required • Establish involvement of law enforcement and other emergency services as needed • Provide education on when and how to access the TFC 24-Hour Crisis Support phone line • Use linguistically appropriate approaches when necessary. • Provide access to Nebraska Relay Service or TDD and staff appropriately trained in the utilization of the service
LENGTH OF SERVICE	The call continues until the pre-crisis or crisis is resolved or emergency assistance arrives, or the caller voluntarily ends the call.
STAFFING	**Licensed Clinicians:** At least one on staff or via consultative agreement to provide clinical direction and support **Direct Care staff:** Must be trained to recognize and respond to a behavioral health crisis.

	Peer Support or Community Treatment Aide: Trained to recognize and respond to a behavioral health crisis **Additional Requirements** • Direct link to law enforcement and other emergency services • Personal recovery experience is preferred for all staffing positions • Personal experience with the foster care system is preferred for all staffing positions
STAFFING RATIO	Adequate staffing to handle call volume
HOURS OF OPERATION	24 hours a day, 7 days a week
CONTINUED STAY REQUIREMENTS	*The individual must meet the Therapeutic Family Care eligibility criteria and all the following Continued Stay Requirements:* 1. The call continues until the pre-crisis or crisis is resolved or a licensed behavioral health professional, law enforcement, or other emergency services are deemed necessary and arrives to offer assistance or the caller voluntarily ends the call.
DESIRED INDIVIDUAL OUTCOME	• Caller experiences a reduction in distress • Caller experiences a reduction in risk of harm to self or others • Caller is referred to appropriate services

Therapeutic Family Care (TFC) Mobile Crisis

TFC Mobile Crisis is designed to use natural supports and resources to manage and resolve an immediate mental health or substance use disorder crisis in the least restrictive environment by creating and implementing a crisis intervention plan with the individual enrolled in the TFC Program and foster family (TFC foster family). This service is delivered in-person in the individual's home or community setting. The desired outcome is resolution of the crisis, ensuring safety and making the necessary referrals and linkages.

SERVICE CATEGORY	Mental health or substance use disorder
SETTING	• Home • Community
BILLING INFORMATION	Fee schedule code for this service is: • H2011 Mobile Crisis 1 Non-Licensed Responder Per (15 minutes) (Crisis Support Service TFC) • H2011 52 Mobile Crisis for Each of 2 Non-Licensed Responders Per (15 minutes) (Crisis Support Service TFC)

	Only approved, enrolled Therapeutic Family Care (TFC) providers may bill for these services. **Telehealth** This service must be provided in person.
ADMISSION REQUIREMENTS	The individual must meet the Therapeutic Family Care eligibility criteria and meet all the following Admission Requirements: • Individual demonstrates active symptomatology consistent with a Diagnostic and Statistical Manual (DSM), current version, diagnosis • Exhibits potential for risk of harm to self or others if support is not provided • Prompt, in-person crisis evaluation and intervention is needed • At risk of being placed in Emergency Protective Custody and/or hospitalized if support is not provided
SERVICE EXPECTATIONS	**Assessments** • In-person meeting with the individual in crisis within one hour from the time of dispatch of TFC Mobile Crisis (2 hours in rural and frontier settings), with response time not to exceed 3 hours • Conduct an evaluation including brief mental health status and substance use disorder screening tools such as SBQR, ASQ, CAGE-AID, CSSRS to ensure the individual is assessed for suicidality, homicidality, substance use disorder, and current symptoms **Safety Planning** • Develop a safety plan such as the Brown-Stanley Safety Plan with the individual and support system **Clinical Services** • Mobile Crisis response, in-person, by 2 team members is preferred. • One or more staff may respond to a crisis and must include or have access to a Licensed Clinician 24/7 • Provide mental health and/or substance use disorder interventions and crisis management • Ensure consultation with hospital emergency personnel, law enforcement, and community agencies as needed • Provide linkage to information and referrals including appropriate community-based mental health and/or substance use disorder services • Provide post crisis follow-up support with the first attempt made within 24 hours and 3 total attempts made within 72 hours including crisis disposition (review of the case and additional referrals for the individual) • Arrange for alternatives to psychiatric hospitalization if appropriate.

	• A licensed clinician must be available at all times to provide support, guidance, and direction to the Mobile Crisis Response team. The clinician must respond within 30 minutes of contact by the team member(s). The response may indicate a need for the clinician to arrive in-person • Non-licensed Certified Peer Support Specialists and Direct Care Staff must be accompanied by another staff member until they have completed all training
LENGTH OF SERVICE	Mobile crisis service continues until the crisis is resolved or the risk of harm to self or others is decreased, and the individual is connected to behavioral health treatment as needed.

STAFFING	**Licensed Clinicians:** At least one on staff or via consultative agreement to provide clinical direction and support
	
	Direct Care staff: Must be trained to recognize and respond to a behavioral health crisis.
	
	Peer Support or Community Treatment Aide:
	Trained to recognize and respond to a behavioral health crisis
	
	Additional Requirements
	Training:
	
	• All staff who respond on-site must be trained in:
	  ○ CPR and First Aid
	  ○ Diversity training
	  ○ Accessing interpretation services
	  ○ Opioid Overdose Safety (Narcan)
	  ○ Trauma Informed Services
	  ○ Mental Health First Aid (All non-licensed staff)
	  ○ At least one suicide intervention and response framework, such as Question, Persuade, Refer (QPR), Assessing and Managing Suicide Risk (AMSR), CAMS-Care Suicide Prevention Training and Response, or Counseling on Access to Lethal Means (CALM)
	  ○ Administering standardized suicide risk screening tools, such as Suicide Behaviors Questionnaire – Revised (SBQ-R), Ask Suicide-Screening Questions Toolkit (ASQ), Columbia-Suicide Severity Rating Scale (CSSRS)
	  ○ Administering substance use screening tools, such as the Cut, Annoyed, Guilty, and Eye – Adapted to Include Drugs (CAGE-AID) questionnaire

	○ Developing safety plans, such as the Stanley-Brown Safety Plan • Mobile Crisis Response teams that provide services to youth must complete youth specific training such as adolescent development, working with CFS or Probation involved youth, EPC alternatives for youth 18 years and under • Direct link to law enforcement and other emergency services • Personal recovery experience is preferred for all staffing positions • Personal experience with the foster care system is preferred for all staffing positions
STAFFING RATIO	• Minimum one-to-one in person; two-to-one is preferred • Response must include or have access to a Licensed Clinician 24/7
HOURS OF OPERATION	24 hours a day, 7 days a week
CONTINUED STAY REQUIREMENTS	*The individual must meet the Therapeutic Family Care eligibility criteria and all the following Continued Stay Requirements:* • Individual continues to meet Admission Requirements.
DESIRED INDIVIDUAL OUTCOME	• The crisis intervention plan for the individual and foster family is developed and implemented • The crisis is resolved, and the individual can safely remain in the TFC foster family unit or is transferred to another level of care that is deemed safer and is the least-restrictive setting for ongoing care

Assessments

Family Assessment

A family assessment is the process of gathering and organizing information about the individual's family. This involves exploration of the family's structure, composition, member relationships, characteristics, interactions, and dynamics. A thorough Family Assessment is the foundation for setting clear, specific, and achievable goals

SERVICE CATEGORY	Mental health or substance use disorder, or both
ALLOWABLE SETTINGS	• Community • Home • Office or Clinic
BILLING INFORMATION	Fee schedule codes for this service are: • H1011 – Family Assessment Assessments provided as part of residential or inpatient mental health or substance use treatment are included in the per diem and are not separately reimbursable **Telehealth** For current telehealth allowances for this service, please refer to the Medicaid Mental Health and Substance Use fee schedule
ADMISSION CRITERIA	• Age: any • A family assessment must be identified in the individual treatment, rehabilitation, and recovery plan
SERVICE REQUIREMENTS	**Assessment** The family assessment must: • Evaluate internal and external factors • Identify family strengths and needs • Develop a plan with the family and define measurable outcomes • Be specific enough to serve as the basis for a treatment plan **Support Services** • Provide consultation, referral, or both for medical, psychological, and psychopharmacology needs

	• Assessments, treatment, and referral must address co-occurring needs • It is the provider's responsibility to coordinate with other treating professionals
LENGTH OF SERVICE	A family assessment must be completed: • Prior to initiation of family psychotherapy services • Annually A family assessment may be completed with clinical justification and prior authorization: • Prior to initiating family or child therapy modalities as required per service description, including Parent-Child Interaction Therapy, Functional Family Therapy, Multisystemic Therapy, or Child-Parent Psychotherapy • When a new licensed clinician takes over the care of an individual • When identified as a treatment need by the treating clinician
STAFFING REQUIREMENTS	Assessments must be provided by licensed clinicians as defined in this document, operating within their professional competencies.
STAFFING RATIO	1 Licensed clinician: 1 Family
HOURS OF OPERATION	To ensure access for all individuals, providers should be able to provide services during evening and weekend hours in addition to typical business hours. Weekend and evening hours may be by appointment as appropriate for established clients if the provider is not typically open outside of business hours.
CONTINUED STAY	N/A
DESIRED INDIVIDUAL OUTCOME	• Assessment of the functional level of the family and its effect on the individual's mental health, substance use disorder, or co-occurring mental health and substance use disorder • Recommendation for treatment goals to increase the individual's level of functioning in relation to the family system

Initial Diagnostic Interview

The Initial Diagnostic Interview (IDI) is a comprehensive biopsychosocial, strengths-based assessment of an individual experiencing mental health and/or co-occurring symptoms. It must be completed prior to the initiation of any non-emergent mental health treatment or rehabilitative service. The Initial Diagnostic Interview is a process of gathering information to assess functioning to determine if the symptoms meet the diagnostic criteria for a mental health or substance use disorder, and to identify treatment needs. The purpose is to rule in or rule out one or more behavioral health disorders. An IDI may serve as a substitute for a substance use disorder assessment if diagnosing substance use disorders is within the provider's professional competencies.

Provisionally licensed clinicians, or clinicians who are not licensed to practice independently (Provisional PhD, LMHP, PLMHP) may only complete the IDI in consultation with an independently licensed clinician, in accordance with the requirements of the DHHS Division of Public Health and the guidelines established in this document

SERVICE CATEGORY	Mental health or substance use disorder, or both
ALLOWABLE SETTINGS	• Community • Home • Office or Clinic • Facility
BILLING INFORMATION	Fee schedule codes for this service are: 90791 – Initial Diagnostic Interview 90792 – Initial Diagnostic Interview with Medical Services 90792 is billable for this service when provided in accordance with this definition as well as the requirements for Medication Management as described in this manual. Assessments provided as part of residential or inpatient mental health or substance use treatment are included in the per diem and are not separately reimbursable **Telehealth** For current telehealth allowances for this service, please refer to the Medicaid Mental Health and Substance Use fee schedule

ADMISSION REQUIREMENTS	N/A

SERVICE REQUIREMENTS	**Assessment**
	The IDI must include, but is not limited to:
	• Reason the individual is seeking services, including maladaptive or problem behaviors and functional status
	• Cultural and ethnic influences
	• Medical history and status, including recommendations for follow up with medical providers when risks are identified
	• Education, military, or work history
	• Mental health and behavioral, cognitive, and emotional functioning status and history
	• Family medical and mental health history
	• Mental status examination
	• Screening for substance use as clinically indicated, including results and recommendations and referral to treatment as appropriate
	• Drug, alcohol, and addictive behavior history, including current use
	• Social relationship history
	• Family relationships, circumstances, custody status, environment and home
	• Strengths, skills, abilities, motivation
	• Legal history
	• Current and past suicide/homicide risk assessment
	• List of current or previously prescribed medications with dosages
	• Trauma screening as clinically indicated and impact on current functioning and behavior, including recommendations for trauma specific follow-up or referral, as applicable
	• Clinical Impression
	  ○ Summary of evaluation
	  ○ Diagnostic impression, including rationale for differential decisions, to include DSM current edition diagnosis
	  ○ Strengths of individual and family identified
	  ○ Problems identified
	  ○ Preliminary recommendations for level of care and necessary interventions directly related to the problems identified
	• A History and Physical (H&P) does not meet the requirements of this definition and may not substitute for an IDI.
	
	Support Services
	
	All individuals are to be screened for co-occurring substance use disorders throughout the IDI. If a co-occurring SUD condition is known or suspected, and diagnosing SUD is not within the licensed clinician's professional competencies, a referral should be made to a licensed clinician who is able to diagnose and treat SUD conditions within their professional competencies and license.

LENGTH OF SERVICE	An IDI must be completed: • Prior to the initiation of mental health or applied behavior analysis treatment services, as required in the service definition. • If the individual is continually engaged in mental health or substance use disorder services, an IDI update or IDI addendum must be completed annually. • As medically necessary. Additional assessment updates may be required if the individual has had significant changes, or if there is a need to establish continued medical necessity. Providers must assess whether a new assessment needs to be completed or if an addendum is adequate An IDI is not required but may be completed more frequently than annually in the following circumstances with clinical justification and prior authorization approval: • When a new licensed clinician takes over the care of the individual • If the individual leaves treatment prior to a successful discharge and fails to return within six months. The provider must assess whether a new IDI needs to be completed or if an IDI addendum is adequate Medicaid will provide reimbursement for three IDIs annually per member, per state fiscal year. Additional IDIs may be requested in certain clinical circumstances for which clinical justification must be submitted for prior authorization and be approved.
STAFFING REQUIREMENTS	Assessments must be provided by licensed clinicians as defined in this document, operating within their professional competencies.
STAFFING RATIO	1 licensed clinician: 1 individual
HOURS OF OPERATION	To ensure access for all individuals, providers should be able to provide services during evening and weekend hours in addition to typical business hours. Weekend and evening hours may be by appointment as appropriate for established clients if the provider is not typically open outside of business hours.
CONTINUED STAY	N/A
DESIRED OUTCOME	Upon completion of the assessment, a diagnosis and any co-occurring diagnoses will be determined, and the individual will be assessed for risk of danger to self or others, or both. Recommendations must be made for additional assessment as clinically indicated. Recommendations must be determined for treatment, recovery, and rehabilitation planning including appropriate level of care, and referrals to appropriate service providers as needed.

Initial Diagnostic Interview Addendum

The Initial Diagnostic Interview addendum (IDI addendum) serves to clarify and update the individual's diagnosis, treatment needs and recommendations for treatment planning. The IDI addendum must gather clinical information that covers the time frame when an individual was not receiving treatment.

Provisionally licensed clinicians, or clinicians who are not licensed to practice independently (Provisional PhD, LMHP, PLMHP) may only complete the IDI in consultation with an independently licensed clinician as required by the DHHS Division of Public Health.

SERVICE CATEGORY	Mental health or substance use disorder, or both
ALLOWABLE SETTINGS	• Community • Home • Office or Clinic • Facility
BILLING INFORMATION	Fee schedule codes for this service are: 90791 52 – Initial Diagnostic Interview Addendum 90792 – Initial Diagnostic Interview with Medical Services Assessments provided as part of residential or inpatient mental health or substance use treatment are included in the per diem and are not separately reimbursable **Telehealth** For current telehealth allowances for this service, please refer to the Medicaid Mental Health and Substance Use fee schedule
ADMISSION REQUIREMENTS	N/A

SERVICE REQUIREMENTS	**Assessment**
	• The IDI addendum must provide updated information on the individual's:
	  ○ Current diagnosis
	  ○ Current functional status
	  ○ Mental status examination
	  ○ Clinically relevant history
	  ○ Risk of danger to self and others
	  ○ Assessment for any co-occurring mental health or substance use disorders

	• The IDI addendum provides updated recommendations for:
	  ○ Level of care
	  ○ Treatment goals
	  ○ Treatment interventions
	  ○ Discharge and transition plan
	  ○ Referrals and resources to community-based support services
	• The addendum must include information that has not been addressed in the clinical notes and capture information that covers any period of time the individual was not receiving treatment
	• A History and Physical (H&P) does not meet the requirements of this definition and may not substitute for an IDI.
	
	Support Services
	• All individuals are to be screened for co-occurring substance use disorders throughout the IDI Addendum. If a co-occurring SUD condition is known or suspected, and diagnosis of SUD is not within the licensed clinician's professional competencies, a referral should be made to a licensed clinician who is able to diagnose and treat SUD conditions within their professional competencies and license

LENGTH OF SERVICE	The IDI addendum must be completed: • When an IDI needs to be updated with new clinical information • When there is a change in clinical status • When an individual has a gap in treatment of less than 6 months • If the individual leaves treatment prior to a successful discharge and fails to return within six months. The provider must assess whether a new IDI needs to be completed or if an IDI addendum is adequate • If the individual is continually engaged in mental health or substance use disorder services, an IDI update or IDI addendum must be completed annually. • As medically necessary. Additional assessment updates may be required if the individual has had significant changes, or if there is a need to establish continued medical necessity. Providers must assess whether a new assessment needs to be completed or if an addendum is adequate Medicaid will provide reimbursement for three IDI addendums annually per individual, per state fiscal year. Additional addendums may be requested in certain clinical circumstances for which clinical justification must be submitted for prior authorization and be approved.
STAFFING REQUIREMENTS	Assessments must be provided by licensed clinicians as defined in this document, operating within their professional competencies.
STAFFING RATIO	1 licensed clinician: 1 individual

HOURS OF OPERATION	To ensure access for all individuals, providers should be able to provide services during evening and weekend hours in addition to typical business hours. Weekend and evening hours may be by appointment as appropriate for established clients if the provider is not typically open outside of business hours.
CONTINUED STAY	N/A
DESIRED OUTCOME	Upon completion of the assessment, a diagnosis and any co-occurring diagnoses will be determined, and the individual will be assessed for risk of danger to self or others, or both. Recommendations must be made for additional assessment as clinically indicated. Recommendations must be determined for treatment, recovery, and rehabilitation planning including appropriate level of care, and referrals to appropriate service providers as needed.

Psychological Evaluation and Testing

Psychological Evaluation and Testing is the administration and interpretation of standardized tests to assess an individual's psychological or cognitive functioning. The assessments and the evaluation process must be age, developmentally, culturally and linguistically appropriate

SERVICE CATEGORY	Mental health
SETTING	• Community • Home • Office or Clinic • Hospital • Facility
BILLING INFORMATION	Fee schedule codes for this service are: • 96116 - Neurobehavioral Status Exam (first 60 minutes) • 96121 - Neurobehavioral Status Exam (additional 60 minutes) • 96130 - Psychological Testing (first 60 minutes) • 96131 - Psychological Testing (each additional hour) • 96132 - Neuropsychological Testing Evaluation (first 60 minutes) • 96133 - Neuropsychological Testing Evaluation (additional 60 minutes) • 96136 - Psychological or Neuropsychological Test Administration and Scoring (first 30 minutes) • 96137 - Psychological or Neuropsychological Test Administration and Scoring (additional 30 minutes) • 96138 - Psychological Test Administration and Scoring by Technician (first 30 minutes) • 96139 - Psychological Test Administration and Scoring by Technician (additional 30 minutes) **Telehealth** For current telehealth allowances for this service, please refer to the Medicaid Mental Health and Substance Use fee schedule
SERVICE REQUIREMENTS	**Assessments** • An Initial Diagnostic Interview (IDI) must be completed prior to testing and must establish the need for this service. The IDI must meet the requirements as noted in the Initial Diagnostic Interview definition in this manual • If an IDI was completed within 12 months prior to admission, and is determined to be clinically relevant, it may serve as the admission IDI. If there has been a gap in treatment of six months or more, or if there is

	new information available, an IDI addendum must be completed and may serve as the admission IDI
	
	If the individual is being treated for a substance use disorder only, a substance use disorder (SUD) assessment may be completed as a substitute for an IDI:
	• An SUD assessment must be completed prior to testing and must establish the need for this service. The SUD assessment must meet the requirements outlined in the SUD Assessment definition in this manual
	  • If an SUD assessment was completed within 12 months prior to admission to the service, and is determined to be clinically relevant, it can serve as the service admission assessment. If there has been a gap in treatment of six months or more, or if there is new information available, an SUD addendum must be completed and may serve as the admission SUD assessment
	• Only psychological tests that are recognized as standardized, valid, and reliable will be considered for prior authorization
	• Results of psychological evaluation and testing must include the following:
	  • Referral question and referral diagnosis
	  • Relevant medical history
	  • Relevant psychosocial history
	  • Sources of information (e.g., patient interview, record review, behavioral observations)
	  • Procedures administered
	  • Clinical decision making
	  • Interpretation of test data and other clinical information (e.g., test results)
	  • Integration of sources of information (e.g., summary and impressions)
	  • Diagnosis
	  • Treatment planning and recommendations
	  • Date(s), billing codes, and amount of time of service
	  • Legible signature of the provider

LENGTH OF SERVICE	• Prior Authorization for Psychological Evaluation and Testing is required, and the request must include which elements of a diagnosis are in question and an explanation as to why these elements cannot be determined by an interview or through observation • Psychological Evaluation and Testing is recommended following an Initial Diagnostic Interview if additional evaluation and testing is needed to make a diagnosis or to formulate a treatment, rehabilitation, and recovery plan

	• Reimbursement is inclusive of the administration, observation, scoring, interpretation, and report writing. Medicaid will reimburse up to a maximum of 1.5 times the standard time it takes to administer the psychological test
STAFFING	**Psychological Evaluation and Testing must be completed by one of the following:** • Psychologist • Provisionally Licensed Psychologist Elements of the assessment may be completed by the following staff, under the supervision of a licensed psychologist: • PhD Intern • Special Licensed PhD
STAFFING RATIO	1 licensed clinician :1 individual
HOURS OF OPERATION	To ensure access for all individuals, providers should be able to provide services during evening and weekend hours in addition to typical business hours. Weekend and evening hours may be by appointment as appropriate for established clients if the provider is not typically open outside of business hours.
CONTINUED STAY	N/A
DESIRED INDIVIDUAL OUTCOME	Upon completion of the assessment, recommendations must be determined for treatment, recovery, and rehabilitation planning including recommended level of care, and referrals to appropriate service providers as needed. Recommendations must be made for additional assessment as clinically indicated. Psychological evaluation and testing contribute to the individual's diagnosis and treatment, rehabilitation, and recovery plan

Sexual Harm Risk Assessment

Sexual Harm Risk Assessment for Youth aged 20 and younger must be a structured evaluation for the purpose of determining whether sex offender specific treatment is needed. The assessment must make recommendations for the following:

- Most appropriate types, intensity and frequency of sex offender treatment
- Safety parameters
- Supervision and monitoring needed during treatment

The assessment must also address treatment needs for medical, mental health or substance use disorders that are diagnosed during the assessment.

The assessment must not be a forensic evaluation.

SERVICE CATEGORY	Mental health or substance use disorder, or both
SETTING	• Community • Home • Office or Clinic • Facility
BILLING INFORMATION	Fee schedule codes for this service are: • H2000 – Risk assessment for youth who sexually harm • H2000 52 – Risk assessment for youth who sexually harm addendum **Telehealth** For current telehealth allowances for this service, please refer to the Medicaid Mental Health and Substance Use fee schedule
ADMISSION REQUIREMENTS	• Age: 20 years of age or younger • Referral for a sexual harm risk assessment (SH risk assessment) must be accompanied by court adjudications, police reports, investigation summaries, other official reports, or evidence of sexually harmful behavior • A licensed clinician with specific expertise and training in assessing individuals with sexually harmful behavior must complete a full review of documented evidence of the individual's sexually harmful behavior, or a face-to-face assessment of the individual, and may recommend the sexual harm risk assessment only after they have determined the individual's presenting problems cannot be adequately assessed through the use of other assessments such as an IDI or standardized psychological testing • The individual is capable of participating in the risk assessment

	• There is an age or developmental differential or both between the alleged perpetrator and victim or non-consensual sexual contact with a peer of similar age or developmental ability or both The behavior being assessed falls outside of what would be considered developmentally appropriate or acceptable for child or adolescent sexual behavior, and there is evidence that the behavior is disabling the individual or preventing them from safely functioning in the home, school or community or completing activities of daily living.

SERVICE EXPECTATIONS	**Assessments**
	• An Initial Diagnostic Interview (IDI) must be completed prior to the SH risk assessment. The IDI must meet the requirements as noted in the Initial Diagnostic Interview definition in this manual and must indicate the need for the SH risk assessment
	• If an IDI was completed within 12 months prior to admission, and is determined to be clinically relevant, it may serve as the admission IDI. If there has been a gap in treatment of six months or more, or if there is new information available, an IDI addendum must be completed and may serve as the admission IDI.
	Clinical Services
	• The SH risk assessment must include:
	  • Demographic information
	  • Individual's history
	  • Mental health
	  • Substance use
	  • Sexual harm history
	  • Trauma and victimization history
	  • Personal strengths
	• Reason for the assessment:
	  • Police and court records
	  • IDI
	  • Interviews with the individual, family, and other relevant contacts
	  • Review of previous assessments and testing
	• Family and social dynamics:
	  • School
	  • Legal
	• Psychological evaluation:
	  • Cognitive and adaptive functioning, if indicated
	  • Sexual misconduct
	• Assessment of:

	• Patterns, perceptions, understanding, motivation, empathy for victim • Supervision and access to victim(s) • Strengths • Risk for reoffending • Treatment recommendations **SH Assessment Addendum** • Addendums to the Sexual Harm Risk Assessment are appropriate when the individual has a subsequent offense and the assessing provider had completed a full risk assessment previously. In these cases, the provider must also update other pertinent information in the initial assessment. The initial Sexual Harm Risk Assessment must be attached to the addendum in order to provide a complete clinical assessment
LENGTH OF SERVICE	N/A
STAFFING	The assessment must be completed by a psychiatrist or Psychologist. Parts of the assessment may be conducted by other licensed clinicians who operate within their professional competencies under the supervision of the psychiatrist or psychologist signing the assessment All clinicians completing the SH risk assessment or elements of the SH risk assessment must have documented education or training in assessing individuals with sexually harmful behavior
STAFFING RATIO	1 licensed clinician: 1 Individual
HOURS OF OPERATION	To ensure access for all individuals, providers should be able to provide services during evening and weekend hours in addition to typical business hours. Weekend and evening hours may be by appointment as appropriate for established clients if the provider is not typically open outside of business hours.
CONTINUED STAY REQUIREMENTS	N/A
DESIRED INDIVIDUAL OUTCOME	All components of the sexual harm risk assessment are completed, and the individual is assessed for risk of danger to self or others, or both. Recommendations must be determined for additional assessment as clinically indicated. Recommendations must be determined for treatment, recovery and rehabilitation planning including appropriate level of care and referrals to appropriate service providers as needed.

Substance Use Disorder Assessment

The substance use disorder (SUD) assessment is an evaluation, using nationally accepted evaluation instruments, to determine if a substance use disorder exists and if so, what appropriate level of intervention is recommended. It must be conducted in accordance with the American Society of Addiction Medicine (ASAM) 4th edition guidelines

Licensed Clinicians who are provisional or not licensed to practice independently (Provisional PhD, LMHP, PLMHP, PLADC) may only complete the SUD assessment in consultation with an independently licensed clinician, in accordance with the requirements of the DHHS Division of Public Health and the guidelines established in this document

SERVICE CATEGORY	Substance use disorder
SETTING	• Community • Home • Office or Clinic • Facility
BILLING INFORMATION	Fee schedule code for this service is: • H0001 – Substance Use Assessment Assessments provided as part of residential or inpatient mental health or substance use treatment are included in the per diem and are not separately reimbursable **Telehealth** For current telehealth allowances for this service, please refer to the Medicaid Mental Health and Substance Use fee schedule
ADMISSION REQUIREMENTS	N/A
SERVICE EXPECTATIONS	**Assessment** The SUD assessment must be comprised of the following components: ***Assessment Tools and Scores*** Evaluation using at least one nationally accepted evaluation instrument, for example the Substance Abuse Subtle Screening Inventory (SASSI). The Addiction Severity Index (ASI) must be used as a structured interview guide, and be scored to provide

	information for the SUD assessment and the multidimensional risk profile ***Comprehensive Biopsychosocial Assessment*** ○ Reason the individual is seeking services, including maladaptive or problem behaviors and functional status ○ Psychosocial history, to include cultural and ethnic influences ○ Medical history and status, including recommendations for follow up with medical providers when risks are identified ○ Education, military, or work history ○ Mental health and behavioral, cognitive, and emotional functioning status and history ○ Preliminary recommendations for level of care and necessary interventions ○ Social and peer-group history ○ Cultural perceptions of use and addiction ○ Safety, support and ability to function in current environment ○ Family relationships, circumstances, custody status, environment and home ○ Strengths, skills, abilities, motivation ○ Legal history and criminogenic risk ○ Current and past suicide/homicide risk assessment ○ Current or previously prescribed medications with dosages ○ Trauma screening and impact on current functioning and behavior, including recommendations for trauma specific follow-up or referral, as applicable ○ Complete ASAM Multidimensional Risk Profile ○ Alcohol or drug history and summary: ▪ Frequency and amount ▪ Drug or alcohol of choice ▪ History of substance induced use or disorder ▪ Use patterns ▪ Consequences of use (physiological, interpersonal, familial, vocational, etc.) ▪ Periods of abstinence, when and why ▪ Tolerance level ▪ Withdrawal history and withdrawal potential ▪ Influence of living situation on substance use ▪ Other addictive behaviors, (e.g., gambling) ▪ IV drug use ▪ Prior substance use disorder evaluations and findings ▪ Prior substance use disorder treatment ▪ Individual's family chemical use history ▪ Substance use related risks (likelihood of engaging in risky substance use behavior) ○ Clinical Impression

	▪ Summary of evaluation ▪ Diagnostic impression, including justification, to include DSM current edition diagnosis ▪ Strengths of individual and family identified ▪ Problems identified ▪ Barriers to care ▪ Patient preferences ▪ Need for motivational enhancement strategies ▪ Social determinants of health ▪ Preliminary recommendations for level of care and necessary interventions. Recommendations for individualized treatment, potential services, modalities, resources, and interventions must be based on the ASAM national criteria multidimensional risk profile. The provider is responsible for referring to the ASAM criteria for the full matrix when applying the risk profile for recommendations. • A History and Physical (H&P) does not meet the requirements of this definition and may not substitute for an SUD assessment. **Support Services** • All individuals are to be screened for co-occurring mental health conditions throughout the SUD assessment. If a co-occurring mental health condition is known or suspected, and diagnosing mental health disorders is not within the licensed clinician's professional competencies, a referral must be made to a licensed clinician who is able to diagnose and treat mental health conditions within their professional competencies and license • Provide access to Medication Assisted Treatment (MAT) as medically appropriate
LENGTH OF SERVICE	An SUD assessment must be completed: • Prior to initiation of substance use disorder treatment services • If the individual is continually engaged in mental health or substance use disorder services, an SUD assessment update or SUD assessment addendum must be completed annually. • As medically necessary. Additional assessment updates may be required if the individual has had significant changes, or if there is a need to establish continued medical necessity. Providers must assess whether a new assessment needs to be completed or if an addendum is adequate

	An SUD assessment is not required but may be completed more frequently than annually in the following circumstances with clinical justification and prior authorization approval: • When a new licensed clinician takes over the care of an individual • If the individual leaves treatment prior to a successful discharge and fails to return within six months. The provider must assess whether a new SUD assessment needs to be completed or if an SUD assessment addendum is adequate Medicaid will provide reimbursement for three SUD assessments annually per individual, per state fiscal year. Additional assessments may be requested in certain clinical circumstances for which clinical justification must be submitted for prior authorization and be approved.
STAFFING	Assessments must be provided by licensed clinicians as defined in this document, operating within their professional competencies.
STAFFING RATIO	1 licensed clinician: 1 Individual
HOURS OF OPERATION	To ensure access for all individuals, providers should be able to provide services during evening and weekend hours in addition to typical business hours. Weekend and evening hours may be by appointment as appropriate for established clients if the provider is not typically open outside of business hours.
CONTINUED STAY REQUIREMENTS	N/A
DESIRED OUTCOME	Upon completion of the SUD assessment, the individual will have been assessed for a SUD diagnosis, assessed for risk of danger to self or others, or both. Recommendations are determined for additional assessment as clinically indicated. Recommendations will be determined for treatment, recovery, and rehabilitation planning, including appropriate level of care and referrals to appropriate service providers as needed

Substance Use Disorder Assessment Addendum

The purpose of the addendum is to clarify and update the individual's diagnosis, treatment needs and recommendations for treatment planning. The SUD assessment addendum must gather clinical information that covers the time frame when an individual was not receiving treatment. It must be conducted in accordance with the American Society of Addiction Medicine (ASAM) 4th edition guidelines

Licensed Clinicians who are provisional or not licensed to practice independently (Provisional PhD, LMHP, PLMHP, PLADC) may only complete the SUD assessment addendum in consultation with an independently licensed clinician, in accordance with the requirements of the DHHS Division of Public Health and the guidelines established in this document

SERVICE CATEGORY	Substance use disorder
SETTING	• Community • Home • Office or Clinic • Facility
LICENSURE, CERTIFICATION, OR ACCREDITATION	Provider licensure and accreditation must be in accordance with the requirements defined in this manual
BILLING INFORMATION	Fee schedule code for this service is: • H0001 52 – Substance Use Assessment - Addendum Assessments provided as part of residential or inpatient mental health or substance use treatment are included in the per diem and are not separately reimbursable **Telehealth** For current telehealth allowances for this service, please refer to the Medicaid Mental Health and Substance Use fee schedule
DEFINITION	The purpose of the addendum is to clarify and update the individual's diagnosis, treatment needs and recommendations for treatment planning. The SUD assessment addendum must gather clinical information that covers the time frame when an individual was not receiving treatment. It must be conducted in accordance with the American Society of Addiction Medicine (ASAM) 4th edition guidelines

ADMISSION REQUIREMENTS	N/A

SERVICE EXPECTATIONS	**Assessment**
	• The SUD assessment addendum must provide updated information on the individual's:
	  ○ Current substance use disorder diagnosis
	  ○ Current functional status
	  ○ Clinically relevant history
	  ○ Risk of danger to self and/or others
	  ○ Assessment for any co-occurring mental health or substance use disorders
	• The SUD assessment addendum provides updated recommendations for:
	  ○ Level of care
	  ○ Treatment goals
	  ○ Treatment interventions
	  ○ Discharge and transition plan
	  ○ Referrals and resources to community-based support services
	• The updated information must be reflective of the individual's current status, any changes in substance use patterns, functioning, and treatment goals
	The addendum must reflect information that has not been addressed in the clinical notes and capture information that covers the period of time outside of treatment
	A History and Physical (H&P) does not meet the requirements of this definition and may not substitute for an SUD addendum.
	Support Services:
	• All individuals are to be screened for co-occurring mental health conditions throughout the SUD assessment. If a co-occurring mental health condition is known or suspected, and diagnosing mental health disorders is not within the licensed clinician's professional competencies, a referral must be made to a licensed clinician who is able to diagnose and treat mental health conditions within their professional competencies and license

	• Provide access to Medication Assisted Treatment (MAT) as medically appropriate
LENGTH OF SERVICE	The SUD assessment addendum must be completed: • When an SUD assessment needs to be updated with new clinical information • When there is a change in clinical status • When an individual has a gap in treatment of less than 6 months • If the individual leaves treatment prior to a successful discharge and fails to return within six months. The provider must assess whether a new SUD assessment needs to be completed or if an SUD assessment addendum is adequate • If the individual is continually engaged in mental health or substance use disorder services, an SUD assessment update or SUD assessment addendum must be completed annually. • As medically necessary. Additional assessment updates may be required if the individual has had significant changes, or if there is a need to establish continued medical necessity. Providers must assess whether a new assessment needs to be completed or if an addendum is adequate Medicaid will provide reimbursement for three SUD assessment addendums annually per individual, per state fiscal year. Additional addendums may be requested in certain clinical circumstances for which clinical justification must be submitted for prior authorization and be approved.
STAFFING	Assessments must be provided by licensed clinicians as defined in this document, operating within their professional competencies.
STAFFING RATIO	1 licensed clinician: 1 Individual
HOURS OF OPERATION	To ensure access for all individuals, providers should be able to provide services during evening and weekend hours in addition to typical business hours. Weekend and evening hours may be by appointment as appropriate for established clients if the provider is not typically open outside of business hours.
CONTINUED STAY REQUIREMENTS	N/A
DESIRED INDIVIDUAL OUTCOME	Upon completion of the substance use disorder assessment addendum, the individual will have been assessed for a substance use disorder diagnosis, an assessment of risk of dangerousness to self or others, or both, and recommendation for treatment, recovery, and rehabilitation planning with the appropriate service level and referrals to appropriate service providers

Applied Behavior Analysis (ABA) Services

Applied Behavior Analysis (ABA) Behavior Identification Assessment

The ABA assessment utilizes multiple methods and input from various sources to ensure a thorough understanding of the patient's functioning at the start of treatment and throughout its progression. The purpose of these assessment activities is to establish the patient's baseline abilities, guide the development of individualized treatment plans and goals, and identify appropriate metrics for tracking progress throughout therapy

The ABA assessment identifies significant, individual-specific factors associated with the occurrence (and non-occurrence) of specific behaviors. The ABA assessment provides information on why the individual engages in the behavior, when the individual is most likely to demonstrate the behavior, and situations in which the behavior is most likely and least likely to occur. Generally, individuals with behavioral issues or functional impairments cannot adequately communicate why they are displaying particular behaviors or what they need to improve in functional skills. By gathering data and conducting evaluations of environmental variables on the individual's behaviors, the assessor can decipher the meaning of a behavior, why it is occurring and help to design and recommend a program of behavioral interventions with the individual and their caregivers who can help the individual acquire needed skills and reduce problematic behaviors

SERVICE CATEGORY	Autism spectrum disorder (ASD), intellectual or developmental disability
ALLOWABLE SETTINGS	• Community • Home • Office or Clinic **ABA Services in school settings: ABA services are covered as part of the Medicaid school-based services program, and are the responsibility of the school as outlined in Nebraska Administrative Code Title 471, Chapter 25 and the Medicaid State Plan. Independent providers may not bill Medicaid directly for services provided at a school. Services provided by the school must meet the requirements for Applied Behavior Analysis as outlined in this document*
BILLING INFORMATION	Fee schedule codes for this service are: • 97151 – Applied Behavior Analysis Behavior Identification Assessment • 97152 – Supporting Assessments for ABA Behavior Identification Assessment

	For more detailed billing information, including current telehealth allowances, please refer to the Medicaid Mental Health and Substance Use Fee Schedule.
TELEHEALTH	Telehealth allowances are outlined per CPT/HCPCS code in the Mental Health and Substance Use Fee Schedule ABA Behavior Identification Assessment by the licensed clinician (CPT 97151) may be completed via audiovisual telehealth if all of the following are true: • Caregivers are available on-site during the ABA assessment in which the licensed clinician is assessing the individual using live, synchronous methods • The environment has been assessed and is safe or there are environmental modifications to ensure the safety of the individual and caregivers • Caregivers have access to technology and a secure internet connection • The individual's behavior is not so severe as to need more than 1:1 support • There are documented plans in place to reduce or eliminate technology-related distractions • The individual has the basic prerequisite skills needed to attend the telehealth evaluation, such as the ability to sit independently at a computer or tablet for 8-10 minutes, and challenging behaviors are low, or can be safely managed by the caregiver • Documentation that justifies the use of telehealth as necessary and formative for the ABA assessment, and not solely for the convenience of the provider or the caregiver ABA Behavior Identification supporting assessment by the technician (CPT 97152) cannot be completed via telehealth Telehealth services, when allowed, must be provided in accordance with the requirements outlined in this manual.
ADMISSION REQUIREMENTS	Age: 0-20 All of the following criteria must be met: • Individual must have a diagnosis of autism spectrum disorder (ASD) or developmental or intellectual disability • An IDI completed by a licensed clinician has identified the need for an ABA assessment to identify and address problematic behaviors in the individual's functioning that are attributed to developmental, cognitive or communication impairments • The individual must present with severe behaviors that cause significant impairments of the individual's life and, without specialized

	ABA assessment and treatment, will likely lead to disrupted placement in their home, school and social environment • The ABA assessment is necessary to inform intensive and specialized treatment planning to address significant behavior impairments *Individuals who are receiving waiver services from the Division of Developmental Disabilities may receive Applied Behavior Analysis Assessments (HCPCS codes 97151 and 97152), regardless of age. For waiver recipients only, the ABA assessment may be recommended and used for non-ABA related purposes. The ABA assessment must meet all other requirements outlined in this document.*

SERVICE EXPECTATIONS	**Assessments**
	
	• If an Initial Diagnostic Interview (IDI) has not been completed within the previous 12 months of the initial ABA assessment, a new IDI or IDI addendum must be completed prior to the initiation of treatment interventions. The IDI must establish the need for the initial ABA assessment. The IDI must meet the requirements as noted in the Initial Diagnostic Interview definition in this manual
	
	  • If an IDI was completed within the past 12 months but there has been a significant change to the individual's clinical presentation, a licensed clinician who is able to diagnose and treat major mental illness within their professional competencies, must review the IDI to determine if the diagnosis and treatment, recovery, and rehabilitation plan are still applicable. If there is new information available, including changes in the treatment, recovery, and rehabilitation plan, an update to the IDI must be documented in the form of an IDI addendum. The IDI addendum must reflect the individual's current functional status
	
	• The IDI must identify the need for the initial ABA assessment.
	• The initial ABA assessment must be completed prior to the initiation of treatment interventions.
	• The ABA Assessment must include the review of:
	
	  • Reason for the assessment
	  • Situational variables
	  • Environmental circumstances
	  • Individual caretaker management practices
	  • Physical health considerations
	  • Academic and social demands
	  • Relevant bio-psychosocial and developmental information
	  • Relevant treatment history and response to treatment efforts

	• Potential barriers to accessing or fully benefiting from care
	
	• The ABA assessment must include:
	
	  • Direct observation in-person or via audiovisual telehealth, when appropriate
	  • Recording of situational factors and the individual's behaviors
	  • Natural observation across multiple settings
	  • Identification of the disruptive behavior
	  • Identification of the contextual factors that contribute to the disruptive behavior, including affective and cognitive factors
	  • Identification of the antecedents and consequences contributing to the identified behavior
	  • Skills-based assessments
	  • Standardized/norm-referenced or criterion-referenced assessments
	  • Risk assessments as clinically indicated for individuals who display challenging behaviors and involve regular screening for the acuity of behaviors and determining the best safety protocols for the individual
	  • Preference assessments to identify the best reinforcers to utilize during behavioral treatment to promote responses
	
	• Collection of information about individual and family functioning, to verify medical and functional history across environments, from (requires appropriate release of information):
	
	  • Parent and primary caregiver interviews
	  • Significant others or family members
	  • Former and current healthcare providers,
	  • Friends and school officials
	
	• Data analysis:
	
	  • Comparison and analysis of collected data to determine if there are patterns associated with the behavioral, emotional, and mental health conditions of concern
	  • Review of the IDI and any other diagnostic assessments to identify other impacts to care. Review of the IDI is necessary to determine what diagnosis and psychosocial factors are impacting behaviors
	
	• The ABA assessment report must include:
	
	  • Diagnosis associated with the reason for seeking assessment
	  • Definition and description of problem behaviors

	• Identified strengths, problems and needs of the individual • Identified strengths and resources of the family • Relationship between the significant behavioral disruption(s) and environmental, cognitive, or emotional variables that contribute to its occurrence • Identification of behavioral and social antecedents, predictors, consequences and reinforcers that maintain the behavior • Explanation of data collection methodology including use of validated rating scales and tools • Summary of the individual's baseline skills • Analysis of any barriers to the individual engaging in treatment • Summary of risky behaviors the individual engages in and proposed plan to reduce risk • Narrative summary of: ▪ Quantitative results with interpretation ▪ Case conceptualization, including proposed intensity and location of services • Targeted behavior management plan comprised of: ▪ Behavior reduction and/or acquisition procedures ▪ Condition(s) under which behavior is to be demonstrated and mastery criteria ▪ Date of introduction ▪ Estimated date of mastery ▪ Plan for generalization ▪ For progress reports, statement as to whether goal or objective is met, not met, or modified (with explanation) ▪ Treatment plan monitoring • Parent and caregiver training, when deemed medically necessary and feasible, must include: • Clearly defined targets, goals, and objectives • Detailed training procedures with date of introduction and estimated date of mastery • Specified service units or hours requested for direct care, caregiver training, clinical oversight, and case supervision ○ The treatment plan must justify medical necessity for each service component and include applicable CPT/HCPCS codes and modifiers. Coordination of care with other providers or services must be documented when relevant

	• The ABA assessment report must be signed by the licensed clinicians who participated in the development of the report, including the supervising practitioner, when applicable • With appropriate releases of information, the ABA assessment report can be shared with other treatment providers involved in the individual's assessment and treatment
LENGTH OF SERVICE	The initial ABA assessment (CPT 97151 with CPT 97152): • One initial assessment for the evaluation of a new patient • CPT 97152 may be performed in combination with CPT 97151 to supplement the ABA assessment • CPT 97152 may not be billed as a stand-alone service • The typical initial ABA assessment takes up to 12 hours. Additional hours may be requested in certain clinical circumstances for which clinical justification must be submitted for prior authorization and be approved The ABA reassessment (CPT 97151 with CPT 97152): • ABA reassessments may be performed at 6-month intervals • CPT 97152 may be performed in combination with CPT 97151 to supplement the ABA assessment • CPT 97152 may not be billed as a stand-alone service • The typical reassessment takes less than 12 hours to complete as it is an update to the initial ABA assessment. Additional hours may be requested in certain clinical circumstances for which clinical justification must be submitted for prior authorization and be approved • Additional brief ABA reassessments may be requested in particular circumstances where an individual's behavior is not responsive to treatment The time to complete an ABA assessment will vary based on the intensity of the individual's behaviors. Direct ABA service hours provided to the individual may not exceed a total of 6 hours per day, except in certain clinical circumstances for which clinical justification must be submitted for prior authorization and be approved. The time requested must be commensurate with the assessments utilized
STAFFING	The ABA assessment must be conducted by a licensed clinician with training and expertise in ABA **Licensed Clinicians who can bill CPT 97151 may include:** • Psychiatrist with training in ABA • Physician with training in ABA

	• Psychologist with training in ABA • Provisionally licensed psychologist with training in ABA • Licensed Behavior Analyst (LBA) As of 01/01/2025, all Board-Certified Behavior Analysts (BCBA) must be licensed as a Licensed Behavior Analyst (LBA), and all Board-Certified assistant Behavior Analysts (BCaBA) must be licensed as a Licensed assistant Behavior Analyst (LaBA) by the Nebraska Department of Public Health as required by Nebraska state law. Technicians who can bill CPT 97152 under the supervision of a licensed clinician may include: • Licensed assistant Behavior Analyst (LaBA) • Registered Behavior Technician (RBT)
STAFFING RATIO	It is a provider's responsibility to ensure their services meet any and all staffing ratio requirements as determined by the Division of Behavioral Health, the Division of Public Health or relevant accrediting body. MLTC regulations do not have specific criteria regarding staffing ratios. An LBA may not supervise more than 24 technicians.
HOURS OF OPERATION	To ensure access for all individuals, providers should have the capacity to provide services during evening and weekend hours in addition to typical business hours. Weekend and evening hours may be by appointment as appropriate for established clients if the provider is not typically open outside of business hours.
CONTINUED STAY REQUIREMENTS	N/A
DESIRED INDIVIDUAL OUTCOME	• The ABA assessment will evaluate maladaptive behavior and be used to design an effective treatment, rehabilitation, and recovery plan to teach the individual functional behaviors to replace maladaptive behaviors. • The ABA assessment will establish baseline levels of social communication skills to design an effective treatment plan • The ABA assessment will identify potential risks and barriers to treatment and include plans to mitigate them

Applied Behavior Analysis (ABA)

ABA is the process of systematically applying interventions based upon the principles of learning theory to improve socially significant behaviors, and to demonstrate that the interventions employed are responsible for the improvement in behavior for individuals with ASD or developmental or intellectual disabilities when it is determined that ABA interventions are needed based on the ABA Behavior Identification Assessment.

SERVICE CATEGORY	Autism spectrum disorder (ASD), intellectual or developmental disability
SETTING	Applied Behavior Analysis (ABA) can be provided in any of the following settings: • Community • Home • Office or Clinic *ABA Services in school settings: ABA services are included in Medicaid school-based services, and are the responsibility of the school as outlined in Nebraska Administrative Code Title 471, Chapter 25 and the Medicaid State Plan. Independent providers may not bill Medicaid directly for services provided at a school. Services provided by the school must meet the requirements for Applied Behavior Analysis as outlined in this document.*
BILLING INFORMATION	Fee schedule codes for this service are: • 97153 - Adaptive Behavior Treatment by Protocol Administered by Technician (per 15 minutes) • 97154 - Group Adaptive Behavior Treatment by Protocol Administered by Technician (per 15 minutes) • 97155 - Adaptive Behavior Treatment by Protocol Administered by Physician or Other Healthcare Professional (per 15 minutes) • 97156 - Family Adaptive Behavior Treatment by Protocol Administered by Physician or Other Healthcare Professional, With or Without Patient Present, With Guardian or Caregiver (per 15 minutes) • 97158 - Adaptive Behavior Treatment Social Skills Group, Administered by Physician or Other Qualified Healthcare Professional with Multiple Patients (per 15 minutes) For more detailed billing information, including current telehealth allowances, please refer to the Medicaid Mental Health and Substance Use Fee Schedule.

TELEHEALTH	Telehealth services are allowed as indicated on the Mental Health and Substance Use fee schedule. Telehealth services must be performed within ethical guidelines for each provider's professional competencies and license. Adaptive Behavior Treatment by the licensed clinician (CPT 97155) with protocol modification may be completed via audiovisual telehealth if all of the following are true: • The individual is receiving 97153 services concurrently • The environment has been assessed and is safe for the individual, family, technician, and others • Caregivers have access to technology and a secure internet connection • The technology available allows the supervisor to effectively see the session, interact with the individual and technician, and give feedback real-time to the participants • The individual's behavior is not so severe as to need more than 1:1 support • There are documented plans in place to reduce or eliminate technology-related distractions • Documentation that justifies the use of telehealth as necessary and formative for the ABA treatment, and not solely for the convenience of the provider or the caregiver Family Adaptive Behavior Treatment by the licensed clinician (CPT 97156) may be completed via audiovisual telehealth if all of the following are true: • Caregivers are actively participating • The environment has been assessed and is safe for the individual, family, technician, and others • Caregivers have access to technology and a secure internet connection • The technology available allows the supervisor to effectively see the session, interact with the individual, family and technician, and give feedback real-time to the participants • The individual's behavior is not so severe as to need more than 1:1 support • There are documented plans in place to reduce or eliminate technology-related distractions • Documentation that justifies the use of telehealth as necessary and formative for the ABA treatment, and not solely for the convenience of the provider or the caregiver Other ABA treatment services (CPT 97153, 97154, 97158) cannot be provided via telehealth. For telehealth requirements and allowances for ABA

	assessments (CPT 97151 and 97152), please refer to the definition in this manual titled *Applied Behavior Analysis Behavior Identification Assessment*

ADMISSION CRITERIA	All of the following criteria must be met for admission to ABA treatment:
	• Individual with a diagnosis of autism spectrum disorder (ASD) or developmental or intellectual disability when it is determined that ABA treatment is needed based on the ABA assessment, who has significant functional impairments resulting from maladaptive behaviors patterns in at least two of the following areas:
	  ○ Non-verbal or limited functional communication and pragmatic language, unintelligible or echolalic speech, impairment in receptive or expressive language
	  ○ Severe impairment in social interaction, social reasoning, social reciprocity, or interpersonal relatedness
	  ○ Frequent intense behavioral outbursts that are self-injurious or aggressive towards others
	  ○ Exhibits atypical, repetitious, or constrained patterns of behavior
	• The presence of maladaptive behaviors negatively impacts the individual's ability to function successfully in home, community, or school settings
	• Of all reasonable options available to the individual, ABA is the best treatment option with expectation of improvement in the individual's behavioral functioning
	• This level of care is the least restrictive setting that will produce the desired results in accordance with the needs of the individual

SERVICE EXPECTATIONS	**Assessments** The following must be completed prior to initiating ABA services and be submitted with the initial prior authorization request: • **Initial Diagnostic Interview (IDI):** if an IDI has not been completed within the previous 12 months of admission to the service, a new IDI or IDI addendum must be completed. The IDI must meet the requirements as noted in the Initial Diagnostic Interview definition in this manual ○ The IDI must establish the need for an Applied Behavior Analysis Behavior Identification Assessment (ABA assessment) and outline the needed services and resources for the individual to make progress toward desired behavior changes. • **ABA Assessment:** must be completed prior to the initiation of ABA treatment interventions and must meet the requirements as outlined in

	the Applied Behavior Analysis Behavior Identification Assessment definition in this manual. **Treatment Planning** An Individualized Treatment, Rehabilitation, and Recovery Plan (treatment plan) must be developed based on the results of the ABA assessment. The treatment plan must be completed prior to initiating ABA services and be submitted with the initial prior authorization request. Ongoing and day to day reassessment and treatment planning are considered part of general treatment services, and are included in current ABA codes Review and update of the treatment plan must occur every 90 days or more often as clinically indicated. Review must be completed by a licensed clinician and include the individual, family, guardians, or other supports as appropriate and authorized by the individual. Regular, thorough reviews of the individual's progress in treatment, with documented updates to progress and revision of goals as needed is an integral part of treatment. This review does not require a full reassessment of the individual. This review is required separately from insurance authorization. The treatment plan must meet the requirements outlined in this document for Individualized Treatment, Rehabilitation, and Recovery plans, and must also include all of the following: • Individual's strengths and needs • Available community, family and other supports • Targeted behaviors to be addressed or skills to be achieved • Long and short-term goals, objectives, and interventions defined in observable, measurable, and behavioral terms for both the individual and caregiver • Inclusion of baseline and ongoing measurement of skills, when applicable, using norm-referenced / standardized assessment tools, for example Vineland, VB-MAPP, ABLLS • Schedule of services being provided to the individual • Documentation of specific setting(s) where services will be delivered and how skills will be generalized and maintained across settings when services are only provided in a single setting • The planned frequency, intensity, and duration of treatment across all settings to reflect the severity of symptoms and impairments, goals of treatment, expected response, and individual variables that may affect the recommended treatment dosage • Frequency must always be commensurate with the individual's age, clinical needs, and level of functioning, as well as evidence-based standards of practice; it is not for the convenience of the caregivers or

	the provider. The treatment plan must include clinical justification for why the requested number of hours is required to meet the individual's specific needs including: ○ What, if any, skills can be treated in a less intensive group format ○ What is the individual's availability to participate in ABA given other commitments (i.e. school, other therapies, family engagements) ○ Impact of co-occurring behavior or medical conditions on skill attainment ○ Overall symptom severity and developmental level of the individual ○ Assessment and documentation of time allotted for individual needs including age-appropriate rest breaks, meals, play, and interaction with peers. Unless there are documented clinical needs in the ABA assessment related to these activities that are linked to goals in the Individualized Treatment, Recovery, and Rehabilitation Plan, these activities are not part of the child's treatment and are not reimbursable but must be accounted for. Naps are never reimbursable and must be accommodated as developmentally appropriate • Any adjustments made to the treatment plan, environment, or protocols to improve progress • Description of how supervision of technicians will be occurring including monitoring for treatment fidelity, what tasks each staff will own, and how progress will reviewed • Evaluation of any barriers to accessing or fully benefiting from services and the proposed plan to manage barriers • Evaluation of needs and a plan to adjust and adapt treatment environments and procedures to account for sensory sensitivities common among individuals with ASD/IDD, such as lighting, sound, and touch preferences • The individual and their caregiver must be involved with treatment planning. Participation by the individual should be age appropriate, and providers may need to adapt their communication strategies to meet the individual's needs, including visual aids, clear and concise language, or alternative communication methods for those with speech and language difficulties <u>School Planning</u> • A school plan is required for all educational settings, to include both public and private schools. This is not required in daycare or after-school settings If ABA therapy is being provided in the school setting, the Individualized Treatment, Rehabilitation, and Recovery Plan must

	outline a separate school plan that is included in the student's IEP. The school plan must: ○ Clearly define the behaviors that are being targeted for reduction specific to this setting ○ List behavior reduction goals ○ Focus on reducing behaviors that impede the individual's ability to engage in academic tasks. Skill development must be focused on school-related behaviors and replacing maladaptive behaviors that impede engagement with academic tasks. ○ ABA therapy in schools or other educational environments should be time limited, and the treatment plan should clearly identify a transition plan and how instructional control will be shifted to school staff **Clinical Services** • ABA behavior interventions may include the following: ○ Family assessment ○ Parent instruction ○ De-escalation techniques ○ Behavior intervention techniques ○ Coping skills ○ Social and life skills development ○ Self-management training • ABA behavior intervention may be delivered as: ○ Individual sessions ○ Group sessions ○ Family sessions • ABA behavior intervention techniques may include: ○ Teaching the individual socially acceptable behaviors via modeling, prompting, roleplaying, and reinforcing appropriate behaviors ○ Providing the family/caregiver with training on acceptable behaviors via modeling, prompting, role playing, and reinforcing appropriate behaviors ○ Supporting development of self-management and token economy systems, working with caregivers to modify the current environment and create supports within the environment including visual schedules

- All services and treatment must be actively engaging and must be carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice
- All services provided must be documented in progress notes

Support Services

- Provide consultation, referral, or both for medical, psychological, and psychopharmacology needs
- Assist the individual and caregiver with accessing community supports and resources. The program must provide the following assistance as appropriate:
    - Coordinate with community resources on behalf of the individual
    - Assist with healthcare navigation
    - Coordinate with and facilitate access to external providers for individuals who require concurrent treatment
    - Assist individuals with application for and access to benefits and social support services
    - Assist individuals with reintegration into the community by identifying and connecting individuals with off-site vocational and educational resources

Discharge Planning

- Discharge planning is an ongoing process that occurs through the duration of service. A documented discharge plan must be completed as part of the Individualized Treatment, Rehabilitation, and Recovery Plan
- A transition plan must be completed prior to discharge. A copy of the transition plan must be given to the individual and to providers at the individual's next level of care, as applicable
- The program must assist individuals with transition and discharge planning. The program must:
    - Coordinate with community resources on behalf of individuals and caregivers to facilitate successful reintegration into daily activity such as work, school, or family living as appropriate
    - Provide referrals and coordinate transition to a lower or higher level of care as clinically indicated
    - Address the individual's ongoing treatment needed to maintain or continue stable physical and mental development post discharge

Caregiver Participation

	Caregivers are essential to the generalization and ongoing maintenance of skills for individuals receiving ABA services. Participation by parents or caregivers is vital to the fidelity of ABA services. Caregiver participation is expected, and continued authorization for ABA services will take into consideration their involvement and ability to reinforce behavior changes over time and across settings. Exceptions to this general expectation may be considered on a case-by-case basis. For example: for an individual in residential placement through the Division of Child and Family Services who has a treatment plan designed to address this limitation. In these cases, persons involved in the individual's care are encouraged to be involved in implementation of the therapeutic interventions in the home and community. Teachers may be considered allowable caregivers for training, but training provided to teachers may not account for more than 25% of required parent or caregiver training hours. IEP meetings are not billable and may not count towards training hours. ABA services will not be denied solely on the basis of lack of parent or caregiver involvement; however, parent or caregiver involvement may affect the effectiveness, durability, and generalizability to natural settings of the treatment and may be considered when making determinations regarding effectiveness of the treatment requested. In cases where caregiver participation is not possible, providers must have documentation of how skills will be maintained upon discharge To support appropriate engagement, ABA providers must: • Include goals for family involvement within the treatment plan • Document family agreement to participate in treatment • Assess for barriers to family engagement, and document a plan for addressing barriers • Ensure family participation. For individuals receiving 10 hours or less per month of ABA services, 1 hour per month is required. For individuals receiving more than 10 hours per month of ABA services, 2-4 hours per month at minimum is required. Inability to meet this requirement must be documented and will be considered on a case-by-case basis • Provide weekend and evening availability for family involvement **ABA is not covered for:** • Diagnoses for which ABA is not evidence-based or for which ABA is not determined to be medical necessary • Intensity and duration of services beyond what is appropriate based on the individual's age, years of treatment, progress toward goals

	• Services focused on recreational, educational, or exclusively self-care goals • Services delivered by 2 LBAs unless non-duplicative and clinically appropriate • Services rendered by someone legally responsible for the individual's care • Services delivered in the school setting as a shadow, or an aide, or to provide general support to the child or youth • Services delivered concurrently (at the same time) as another treatment modality (i.e. ST, OT, PT) • LBAs are not permitted as the sole provider of a feeding treatment plan
LENGTH OF SERVICE	Length of service is individualized and based on clinical criteria for admission and continuing stay as well as the individual's ability to make progress on individual goals. The anticipated duration of the service must be documented in the Individualized Treatment, Rehabilitation, and Recovery Plan. Direct ABA service hours provided to the individual may not exceed 6 hours in a single day or a total of 20 hours per week. • Treatment takes into consideration the developmental level of each individual, and treatment schedule considers the needs of the individual including rest and nutrition breaks and interactions with peers • Additional daily or weekly treatment hours may be requested in certain clinical circumstances for which clinical justification must be submitted for prior authorization and be approved
STAFFING	ABA services must be provided by or under the supervision of a licensed clinician with training and expertise in ABA. Clinicians are expected to adhere to applicable ethical guidelines for their discipline. **Licensed Clinicians may include:** • Psychiatrist with training in ABA • Physician with training in ABA • Psychologist with training in ABA • Provisionally licensed psychologist with training in ABA • Licensed Behavior Analyst (LBA) Technicians who can bill CPT 97153, 97154 under the supervision of a licensed clinician may include: • Licensed assistant Behavior Analyst (LaBA) • Registered Behavior Technician (RBT)

As of 01/01/2025, all Board-Certified Behavior Analysts (BCBAs) must be credentialed as a Licensed Behavior Analyst (LBA), and all Board-Certified assistant Behavior Analysts (BCaBAs) must be credentialed as a Licensed assistant Behavior Analyst (LaBA) by the Nebraska Department of Public Health as required by Nebraska state law.

Supervision

Provisionally licensed psychologists providing ABA services must be supervised by a licensed psychologist with training in ABA.

ABA services performed by a Licensed assistant Behavior Analyst (LaBA) must be provided under the supervision and direction of an LBA.

Services provided by a Registered Behavior Technician (RBT), must be provided under the supervision and direction of a Licensed Behavior Analyst or a psychologist with training in ABA.

- Supervision entails the following: critical oversight of a treatment activity or course of action; review of the treatment plan and progress notes; individual specific case discussion; periodic assessments of the individual; and diagnosis, treatment intervention or issue specific discussion
- Direct supervision by observation of the technician must occur no less than 10% of direct service hours (97153/97154/97155) provided in a week. Supervision must be documented in progress notes. Failure to meet 10% of direct service hours must be documented, including the reason that the supervision did not take place and a corrective action plan
- The supervisor must provide direct supervision by observation of the technician or LaBA in person for at least one hour per month.
- Involvement of the supervising practitioner must be reflected in the treatment plan, and documentation of the interventions provided
- The treating LBA or psychologist must provide at least one hour of in-person, direct services to the individual receiving services at least monthly
- Behavior analysts must identify their services accurately and include all required information on reports, bills, invoices, requests for reimbursement, and receipts
- ABA providers must not implement or bill nonbehavioral services under an authorization or contract for behavioral services. Examples include, but are not limited to: naps, extended

	recreational reinforcement, meals without active goals and treatment, extended breaks in active intervention
STAFFING RATIO	97151 – 1 licensed clinician: 1 child 97152 – 1 technician: 1 child 97153 – 1 technician: 1 child 97154 - 1 technician: 2-5 children 97155 – 1 licensed clinician: 1 child 97156 - 1 licensed clinician: 1 family 97158 - 1 licensed clinician: 2-5 children An LBA may not supervise more than 24 technicians
HOURS OF OPERATION	To ensure access for all individuals, providers should have the capacity to provide services during evening and weekend hours in addition to typical business hours. Weekend and evening hours may be by appointment as appropriate for established clients if the provider is not typically open outside of business hours.
CONTINUED STAY REQUIREMENTS	All of the following criteria must be met for continuing treatment at this level of care: • The acuity of the individual's symptoms continues to necessitate treatment at the current level of care based on admission criteria • The individual does not require a more intensive level of services and no less intensive level of care is appropriate • The individual's treatment plan is up to date, with targets that are appropriate and related to improvement in the individual's symptoms and achievement of their goals. ▪ The individual is making progress towards rehabilitation goals and they are showing progress towards symptom reduction as demonstrated by objective behavioral measurement of functional improvement or standardized report from the member or guardian of symptom and/or functional improvement. Preferred assessment tools:Vineland-3 ▪ Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP) ▪ Assessment of Basic Language & Learning Skills (ABLLS) ○ Behavioral assessments must be documented within the updated treatment plan

	• If progress has not been made or symptoms are increased, the treatment plan has been modified to focus on any new symptoms or to address barriers to progress. • There is evidence that the treatment team is working towards a transition plan to meet the individual's treatment needs once this level of care is no longer appropriate. • Caregivers are participating in treatment a minimum of 2-4 hours per month to support generalization and maintenance of skills
DESIRED INDIVIDUAL OUTCOME	Discharge should occur when documentation indicates improvement from baseline in targeted skill deficits and behaviors to the extent that goals are achieved, or maximum benefit has been reached as evidenced by any of the following: • Functional improvement has been made to the extent possible and further progress is not occurring as measured by assessments over two consecutive authorization periods • Symptoms no longer materially impact functioning • Symptoms can be managed by less intensive or alternative services • Caregiver is able to implement ABA strategies without additional specialized support • Caregiver is not engaged in treatment or inhibits progress • Inability to reconcile differences between caregivers and ABA providers • Treatment is worsening behavior or symptoms, and no changes have been made to the treatment plan to address barriers to progress • ABA is no longer the most appropriate or least costly service, and the individual can be safely and effectively treated through alternative modalities • Services continued for longer than 6 months without demonstrated progress or no changes have been made to the treatment plan to address barriers to progress • The precipitating condition has stabilized such that the individual's condition can be managed without specialized ABA supports and interventions • The individual and guardian have support systems in place to help the individual maintain stability in the community

Clinic and Community Based Services

Assertive Community Treatment

The assertive community treatment (ACT) team provides high intensity services, and is available to provide treatment, rehabilitation, and support activities seven days per week, 24 hours per day, and 365 days per year. The team has the capacity to provide multiple contacts each day as dictated by individual need. The team provides ongoing continuous care for individuals determined to have met medical necessity.

SERVICE CATEGORY	Mental health
SETTING	• Community • Home • Office or Clinic • This service may not be provided in an Assisted Living Facility or Nursing Facility
BILLING INFORMATION	**Fee schedule codes for this service are:** • H0040 Assertive Community Treatment Program (ACT), Psychiatrist providing all Med Services (per diem) • H0040 52 Assertive Community Treatment Program (ACT), APRN Providing Some Med Services (per diem) **Telehealth** This service must be provided in person.
ADMISSION CRITERIA	Age: 21 years of age and older – for youth eligibility, refer to EPSDT requirements as outlined in the definition section of this manual. • The individual demonstrates symptomatology consistent with a diagnosis as outlined in the current editions of the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association, which requires and can reasonably be expected to respond to therapeutic intervention • It is expected that the individual will be able to benefit from this treatment • This level of care is the least restrictive setting that will produce the desired results in accordance with the needs of the individual

	• The individual is at significant risk of institutionalization if needed mental health services are not provided
	  ○ The individual has a pattern of high utilization of psychiatric inpatient, emergency services, admissions to a state mental health hospital, or involvement in competency restoration within the past 12 months
	• The individual has had less than satisfactory response to previous levels of treatment or rehabilitation interventions
	• Serious mental illness as evidenced by functional limitations related to the diagnosis that seriously interfere with the individual's ability to function independently in an appropriate manner in two of three functional areas:
	  ○ Instrumental activities of daily living: inability to be employed or an ability to be employed only with extensive supports; deterioration or decompensation resulting in inability to establish or pursue educational goals within normal time frame or without extensive supports; or inability to consistently and independently carry out home management tasks
	  ○ Social functioning: repeated inappropriate or inadequate social behavior or ability to behave appropriately only with extensive supports; or consistent participation in adult activities only with extensive supports or when involvement is mostly limited to special activities established for persons with mental illness; or history of dangerousness to self or others.
	  ○ Activities of daily living: inability to consistently perform the range of practical daily living tasks required for basic adult functioning as evidenced by functional limitations in at least three of the following areas:
	  ▪ Grooming, hygiene, washing clothes, meeting nutritional needs
	  ▪ Care of personal business affairs
	  ▪ Transportation and care of residence
	  ▪ Procurement of medical, legal, and housing services
	  ▪ Recognition and avoidance of common dangers or hazards to self and possessions

SERVICE EXPECTATIONS	**Assessments** • If an IDI was completed within 12 months prior to admission, and is determined to be clinically relevant, it may serve as the admission IDI. If there has been a gap in treatment of six months or more, or if there is new information available, an IDI addendum must be completed and may serve as the admission IDI. • If an Initial Diagnostic Interview (IDI) has not been completed within the 12 months prior to admission, a new IDI or IDI addendum must be completed within 24 hours of the beginning of treatment. The IDI must meet the requirements as noted in the Initial Diagnostic Interview definition in this manual **Treatment Planning**

- An initial treatment plan must be developed upon admission to guide the first 30 days of treatment
- Under clinical supervision, develop an Individualized Treatment, Rehabilitation, and Recovery Plan, including discharge plan, with the individual within 30 days of admission
- Review and update the Individualized Treatment, Rehabilitation, and Recovery Plan every 90 days or more often as clinically indicated. Review must be completed with the individual under the direction of a licensed clinician and must include family, guardians, other supports as authorized by the individual

Clinical Services

- Facilitate access to treatment for identified physical health needs
- Provide individual, family, and group therapy
- Refer to support group services as appropriate
- Weekly medication management with the ACT Psychiatrist or APRN as clinically indicated
- Provide medication management delivery, administration and monitoring as clinically indicated
- Provide crisis intervention as required
- Provide rehabilitation services and education, including symptom management, skill development, vocational skill development, and psycho-educational services focused on activities of daily living, social functioning, and community living skills
- Provide supportive interventions which include direct assistance and coordination in obtaining basic necessities such as medical appointments, housing, transportation, and maintaining family and community involvement with the individual.
- Offer opportunities for positive peer role modeling and peer support.
- Conduct daily ACT team meetings. Team meetings must include the following:
    - Review the functional status and needs of the individual
    - Review clinical needs
    - Identify current and potential issues and concerns
    - The team psychiatrist and team leader must provide clinical direction weekly. Clinical direction may occur during daily team meetings, individual treatment, rehabilitation and recovery plan meetings, supervision sessions and record reviews.

Support Services

- Provide access to Medication Assisted Treatment (MAT) as medically appropriate
- Provide access to a Physician or APRN for a physical exam as clinically indicated
- Provide consultation, referral, or both for medical, psychological, and psychopharmacology needs if not provided by the ACT team

	• Assist the individual with accessing community supports and resources. The program must provide the following assistance as appropriate:
	  • Coordinate with community resources on behalf of the individual
	  • Assist with healthcare navigation
	  • Coordinate with and facilitate access to external providers for individuals who require concurrent treatment
	  • Assist individuals with application for and access to benefits and social support services
	  • Assist individuals with reintegration into the community by identifying and connecting individuals with off-site vocational and educational resources
	
	Discharge Planning
	• Discharge planning is an ongoing process that occurs through the duration of service. A documented discharge plan must be completed as part of the Individualized Treatment, Rehabilitation, and Recovery Plan
	• A transition plan must be completed prior to discharge. A copy of the transition plan must be given to the individual and to providers at the individual's next level of care, as applicable
	• The program must assist individuals with transition and discharge planning. The program must:
	  • Assist individuals with identifying and accessing housing resources if being discharged to independent living
	  • Coordinate with community resources on behalf of individuals to facilitate successful reintegration into daily activity such as work, school, or family living as appropriate
	  • Provide referrals and coordinate transition to a lower or higher level of care as clinically indicated

LENGTH OF SERVICE	Length of service is individualized and based on clinical criteria for admission and continuing stay. The anticipated duration of the service must be documented in the treatment, recovery, and rehabilitation plan.
STAFFING	**Minimum Configuration for ACT teams serving 1-50 individuals:** **Medical Director** Must be one of the following: • Psychiatrist • APRN with 5 years of experience or education in psychiatric treatment A consulting psychiatrist must be available, if not in the medical director position **Team Leader** Must be one of the following: • Psychiatrist • Physician

- Psychologist
- Provisionally licensed psychologist
- Advanced practice registered nurse (APRN)
- Physician Assistant (PA)
- Licensed Independent Mental Health Practitioner (LIMHP)
- Licensed Mental Health Practitioner (LMHP)

Mental Health Specialist
Must be one of the following:

- Provisionally licensed psychologist
- Advanced practice registered nurse (APRN)
- Physician Assistant (PA)
- Licensed Independent Mental Health Practitioner (LIMHP)
- Licensed Mental Health Practitioner (LMHP)
- Provisionally Licensed Mental Health Practitioner (PLMHP)

Substance Use Specialist
Must be one of the following:

- Licensed alcohol and drug counselor (LADC)
- Provisionally licensed alcohol and drug counselor (PLADC)

Nurse
Must be:

- RN with experience or education in psychiatric treatment, or
- LPN under RN supervision, with experience or education in psychiatric treatment

Peer Support Specialist
Must be:

- Certified Peer Support Provider

Vocational Specialist
Must be an individual who meets the following requirements:

- High school diploma or GED
- One year of training or experience in vocational rehabilitation and support

Program Assistant (optional)

- High school diploma or GED

Direct Care staff (optional)

Expanded Configuration:

	If the ACT team serves more than 50 individuals, then all of the following additional staff members are required: • At least one additional RN or LPN, and mental health professional • A full-time Certified Peer Support Specialist and • For every additional eight individuals, the psychiatrist or APRN will be available an additional 2.6 hours If the ACT team serves more than 100 individuals, then the following additional staff members are required: • A full-time psychiatrist. Increases in the size of the program should reflect a proportional increase in psychiatrist hours and availability • Two full-time RNs, two substance abuse specialists, and two vocational specialists • There should be a proportional increase in staff hours for the RN, vocational specialist, and substance abuse treatment specialist to address needs of the additional individuals
STAFFING RATIO	Team member to individual ratio is 1:10. Team member to individual ratio does not include the team psychiatrist, APRN, or those providing clerical or administrative support.
HOURS OF OPERATION	Weekdays: Staff must be available 12 hours per day Weekends and holidays: Staff must be available eight hours per day At least one ACT team member must be available on-call 24 hours a day and able to provide crisis response and assistance. Team members providing clerical or administrative support may not serve as an on-call staff member.
CONTINUED STAY REQUIREMENTS	All of the following criteria must be met for continuing treatment at this level of care: • The acuity of the individual's symptoms continues to necessitate treatment at the current level of care based on admission criteria • The individual does not require a more intensive level of services and no less intensive level of care is appropriate • The individual's treatment plan is up to date, with targets that are appropriate and related to improvement in the individual's symptoms and achievement of their goals. • The individual is making progress towards rehabilitation goals and they are showing progress towards symptom reduction as demonstrated by objective behavioral measurement of functional improvement or standardized report from the member or guardian of symptom and/or functional improvement. This progress can be documented by objective evidence of reduced rate of accessing emergency or hospital services

	• If progress has not been made or symptoms are increased, the treatment plan has been modified to focus on any new symptoms or to address barriers to progress. • Attempts to increase the individual's level of independence have been unsuccessful and have led to documented increase in symptoms. Increases in independence and evaluation of progress should take into account the patient's history of relapse and the severity of prior symptoms • There is evidence that the treatment team is working towards a transition plan to meet the individual's treatment needs once this level of care is no longer appropriate.
DISCHARGE CRITERIA	Discharge should occur when documentation indicates improvement from baseline in targeted skill deficits and behaviors to the extent that goals are achieved, or maximum benefit has been reached as evidenced by any of the following: • The individual has met their treatment plan goals and objectives • The individual has clinically appropriate support systems secured to help the individual manage symptoms and maintain stability in the community • Symptoms are increased or not improving, and no changes have been made to the treatment plan to address barriers to progress • Symptoms no longer materially impact functioning • Symptoms can be managed by less intensive or alternative services • The individual refuses continued treatment

Certified Peer Support Services

Certified Peer Support services are provided by individuals who have lived experience with mental health or substance use disorders (SUD). This service is person-centered and designed to assist individuals in initiating and maintaining the process of recovery and resiliency to improve their quality of life, health, and wellness. Certified Peer Support services support individuals to live self-directed lives striving to reach their full potential through self-advocacy and empowerment

The Certified Peer Support provider acts as an advocate, mentor, or facilitator for resolution of issues related to the individual's mental illness or substance use disorder

SERVICE TYPE	Mental health, substance use disorder, or both
ALLOWABLE SETTINGS	• Community • Home • Office or Clinic
Billing	Fee schedule codes for this service are: • H0038 HE Certified Peer Support Services - MH (15 minutes) • H0038 HE HQ Certified Peer Support Group Services – PH (15 minutes) • H0038 HF Certified Peer Support Services – SUD (15 minutes) • H0038 HF HQ Certified Peer Support Group Services - SUD (15 minutes) Certified Peer Support is an ancillary service and must be provided in conjunction with one or more behavioral health services provided by a licensed clinician (e.g. psychotherapy, medication management). The individual must have at least one billable encounter with a licensed clinician or medication management provider for every 60 days of peer support Peer support services provided as part of residential or inpatient mental health or substance use treatment are included in the per diem and are not separately reimbursable **Telehealth** 1 face to face visit every 30 days is required in order to provide this service via telehealth
Admission requirements	**For Peer Support MH Services:** The individual demonstrates symptomatology consistent with a mental health disorder diagnosis as outlined in the current editions of the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American

	Psychiatric Association, which requires and can reasonably be expected to respond to therapeutic intervention **For Peer Support SUD Services:** • The individual demonstrates symptomatology consistent with a substance use disorder diagnosis as outlined in the current editions of the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association, which requires and can reasonably be expected to respond to therapeutic intervention. **For all Peer Support Services:** • The individual is receiving active treatment for a mental health or substance use disorder • The reason for peer support services, and peer support goals must be documented in the Individualized Treatment, Rehabilitation, and Recovery plan
Service Expectations	**Assessments** • If an IDI was completed within 12 months prior to admission, and is determined to be clinically relevant, it may serve as the admission IDI. If there has been a gap in treatment of six months or more, or if there is new information available, an IDI addendum must be completed and may serve as the admission IDI. • If an Initial Diagnostic Interview (IDI) has not been completed within the 12 months prior to admission, a new IDI or IDI addendum must be completed within 24 hours of the beginning of treatment. The IDI must meet the requirements as noted in the Initial Diagnostic Interview definition in this manual *If the individual is being treated for a substance use disorder only, a substance use disorder (SUD) assessment may be completed as a substitute for an IDI:* • An SUD assessment must be completed prior to the beginning of treatment and must establish the need for this service. The SUD assessment must meet the requirements outlined in the SUD Assessment definition in this manual ○ If an SUD assessment was completed within 12 months prior to admission to the service, and is determined to be clinically relevant, it can serve as the service admission assessment. If there has been a gap in treatment of six months or more, or if there is new information available, an SUD addendum must be completed and may serve as the admission SUD assessment **Peer Support Services** • Educate the individual about the Certified Peer Support relationship, including healthy personal boundaries, individual rights, and the significance of shared decision making

	• Model and present self-help activities to enhance the individual's ability to make informed, independent choices and decisions. These activities should be designed to assist the development of a personal network of support, enhance problem solving abilities, and build personal confidence in the individual's ability to improve health and well-being
	• Build on current strengths of the individual to empower them with advocacy and self-help skills to enhance their process of recovery and increase their capacity to utilize wellness options available
	• Identify, assist with access, and advocate for participation in any services that will aid in daily living, coping, or symptom management
	• Provide peer coaching to facilitate the individual's system navigation, access to community resources, and engagement with formal and informal resources and supports
	• Provide person-centered recovery tools while helping to ensure the Individualized Treatment, Rehabilitation, and Recovery Plan reflects the needs and preferences of the individual
	• Assist the individual in determining the steps they need to take in order to achieve the goals identified on the Individualized Treatment, Rehabilitation, and Recovery Plan
	• Assist the individual with locating and joining self-help groups
	• Share recovery experiences, problem solving skills, strengths, supports, and resources used in order to benefit the individual by demonstrating wellness and effective symptom management
	• Meet the individual "where they are" in their recovery process and encourage engagement in services
	
	Family Setting
	• Family Certified Peer Support Services are available to parents or legal guardians of children:
	  ○ Services must be directed primarily toward the benefit of the child. The reason for services must be documented in the clinical record
	  ○ The peer support provider should be an individual in recovery from mental illness or substance use, a parent of a child with a similar mental illness or substance use disorder or an adult with an ongoing or personal experience with a family member with a similar mental illness or substance use disorder
	  ○ Provide Peer Support services as listed above to the individual and family
	
	Support Services
	• Provide access to Medication Assisted Treatment (MAT) as medically appropriate
	• Provide access to a Physician or APRN for a physical exam as clinically indicated

	• Provide consultation, referral, or both for medical, psychological, and psychopharmacology needs
	• Assist the individual with accessing community supports and resources. The program must provide the following assistance as appropriate:
	  ○ Coordinate with community resources on behalf of the individual
	  ○ Assist with healthcare navigation
	  ○ Coordinate with and facilitate access to external providers for individuals who require concurrent treatment
	  ○ Assist individuals with application for and access to benefits and social support services
	  ○ Assist individuals with reintegration into the community by identifying and connecting individuals with off-site vocational and educational resources
	
	Discharge Planning
	• Discharge planning is an ongoing process that occurs through the duration of service. A documented discharge plan must be completed as part of the Individualized Treatment, Rehabilitation, and Recovery Plan
	• A transition plan must be completed prior to discharge. A copy of the transition plan must be given to the individual and to providers at the individual's next level of care, as applicable
	• The program must assist individuals with transition and discharge planning. The program must:
	  ○ Assist individuals with identifying and accessing housing resources if being discharged to independent living
	  ○ Coordinate with community resources on behalf of individuals to facilitate successful reintegration into daily activity such as work, school, or family living as appropriate
	  ○ Provide referrals and coordinate transition to a lower or higher level of care as clinically indicated

Length of Service	**Clinical Involvement:** Length of service is individualized and based on clinical criteria for admission and continuing stay. The anticipated duration of the service must be documented in the treatment, recovery, and rehabilitation plan
Staffing	**Clinical Supervisor:** Must be one of the following: • Psychiatrist • Physician • Psychologist • Provisionally licensed psychologist

	• Advanced practice registered nurse (APRN) • Physician assistant (PA) • Licensed independent mental health practitioner (LIMHP) • Licensed mental health practitioner (LMHP) • Provisionally licensed mental health practitioner (PLMHP) ***If providing services for substance use only, the clinical supervisor may also be:*** • Licensed alcohol and drug counselor (LADC) • Provisionally licensed alcohol and drug counselor (PLADC) *Supervision of Certified Peer Support Providers:* • Supervision of Certified Peer Support Providers by an approved supervisor is required at least once per month • The supervisor must be available at all times for telephone consultation • The supervising practitioner assumes professional responsibility for the services provided by the Certified Peer Support provided • Documentation of supervision must be documented in the clinical record • Supervision is not a billable service **Certified Peer Support providers:** as needed to meet staffing ratio
Staffing Ratio	• 1 Certified Peer Support provider: 25 individuals • Certified Peer Support services in a group setting: ○ One Certified Peer Support provider: 3-12 individuals • 1 Clinical supervisor: 6 Certified Peer Support providers
Hours of Operation	To ensure access for all individuals, providers should be able to provide services during evening and weekend hours in addition to typical business hours. Weekend and evening hours may be by appointment as appropriate for established clients if the provider is not typically open outside of business hours.
Continued Stay Requirements	All of the following criteria must be met for continuing treatment at this level of care: • The acuity of the individual's symptoms continues to necessitate treatment at the current level of care based on admission criteria • The individual is engaged with clinical services in addition to peer support but does not require a more intensive level of services, and discharge or discontinuation of services is not clinically appropriate

	• The individual's treatment plan is up to date, with targets that are appropriate and related to improvement in the individual's symptoms and achievement of their goals. • The individual is making progress towards rehabilitation goals and they are showing progress towards symptom reduction as demonstrated by objective behavioral measurement of functional improvement or standardized report from the member or guardian of symptom and/or functional improvement. • If the individual is not engaged with clinical services, or progress has not been made or symptoms are increased, the treatment plan has been modified to focus on any new symptoms or to address barriers • There is evidence that the treatment team is working towards a transition plan to meet the individual's needs once this level of care is no longer appropriate.
Desired Individual Outcome	• The individual has substantially met the treatment, recovery, and rehabilitation plan goals and objectives • The precipitating condition and relapse potential is stabilized such that there is sustained improvement in health and psychosocial functioning • The individual's condition can be managed without the professional external supports and intervention at this level of care • The individual has alternative support systems secured to help maintain active recovery and stability in the community • The individual is connected to the next appropriate level of care necessary to treat the condition

Child Parent Psychotherapy

Child Parent Psychotherapy (CPP) is provided to children birth to age five, who have experienced at least one traumatic event e.g., maltreatment, the sudden or traumatic death of someone close, a serious accident, sexual abuse, exposure to domestic violence, and, as a result, are experiencing behavior, attachment, or mental health problems, including post-traumatic stress disorder (PTSD).

The goals of CPP must include:

- Supporting and strengthening the relationship between the child and the parent or primary caregiver
- Restoring the child's sense of safety and attachment,
- Improving the child's cognitive, behavioral, and social functioning

The purpose of the therapeutic sessions must be to increase the individual's functional level and recovery by altering the family system and focusing interventions on the family unit. These services must focus on the functioning of the family system as a whole.

SERVICE TYPE	Mental health
ALLOWABLE SETTINGS	• Community • Home • Office or Clinic
BILLING INFORMATION	Fee schedule code for this service is: • 90847 U8 – Child Parent Psychotherapy (CPP) **Telehealth** For current telehealth allowances for this service, please refer to the Medicaid Mental Health and Substance Use fee schedule
ADMISSION CRITERIA	• Age: birth to five years of age ○ Individuals outside of this age range who are aged 20 or younger may be approved for services if clinical justification is submitted for prior authorization and approved • The individual demonstrates symptomatology consistent with a diagnosis as outlined in the current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association, which requires and can reasonably be expected to respond to therapeutic intervention. • There are significant symptoms, caused by the behavioral health disorder diagnosis, that negatively impact a child's ability to eat, sleep, engage in age-appropriate social behavior, and meet developmentally appropriate milestones.

	• Of all reasonable options available to the individual, this service is the best treatment option with expectation of improvement in the individual's behavioral functioning. • CPP is required for reasons other than primarily for the convenience of the individual or the provider. • CPP is identified in the treatment plan as a treatment intervention for the individual.
SERVICE EXPECTATIONS	**Assessments:** • Prior to CPP services, a medical evaluation must be performed by a physician or APRN to rule out any medical conditions which may cause or contribute to the child's behavior • If an IDI was completed within 12 months prior to admission, and is determined to be clinically relevant, it may serve as the admission IDI. If there has been a gap in treatment of six months or more, or if there is new information available, an IDI addendum must be completed and may serve as the admission IDI • If an Initial Diagnostic Interview (IDI) has not been completed within the 12 months prior to admission, a new IDI or IDI addendum must be completed within 24 hours of the beginning of treatment. The IDI must meet the requirements as noted in the Initial Diagnostic Interview definition in this manual • A family assessment must be performed at the onset of CPP. The family assessment must meet the requirements as noted in the Family Assessment definition in this manual **Treatment Planning** • An initial treatment plan must be developed within 24 hours of admission to guide the first 30 days of treatment • Under clinical supervision, develop an Individualized Treatment, Rehabilitation, and Recovery Plan, including discharge plan, with the individual within 30 days of admission • Review and update the Individualized Treatment, Rehabilitation, and Recovery Plan every 90 days or more often as clinically indicated. Review must be completed with the individual under the direction of a licensed clinician and must include family, guardians, other supports as authorized by the individual **Clinical Services** • Services must follow CPP clinical protocols and best practices, and must be tailored to each individual's level of clinical severity and designed to help the individual achieve changes in their symptoms • Provide training to the individual and their family, guardian, or caregivers in socially acceptable behaviors via modeling, prompting, roleplaying, and reinforcement of appropriate behaviors to promote consistency for the individual • Services must involve the child and their family, guardian, or caregivers for the purpose of changing behavior, focusing on the level of family

	functioning as a whole and addressing issues related to the entire family system • All members of the family residing in the same household as the individual must participate in treatment as clinically appropriate • The goals, frequency, and duration of treatment will vary according to individual needs and response to treatment • During the therapy process, collaborative, person-focused progress tracking should be supported by periodic collection of objective behavioral indicators of functional status and/or standardized reports of symptom burden and functional status from the individual or their guardian. Reviewing these measures and their patterns over time directly with the individual or guardian helps ensure care remains aligned with their goals, supports shared decision-making, and promotes meaningful progress toward improved well-being **Support Services** • Provide access to Medication Assisted Treatment (MAT) as medically appropriate • Provide consultation, referral, or both for medical, psychological, and psychopharmacology needs • It is the provider's responsibility to coordinate with other treating professionals **Discharge Planning** • Discharge planning is an ongoing process that occurs through the duration of service. A documented discharge plan must be completed as part of the Individualized Treatment, Rehabilitation, and Recovery Plan • A transition plan must be completed prior to discharge. A copy of the transition plan must be given to the individual and to providers at the individual's next level of care, as applicable
LENGTH OF SERVICE	Length of service is individualized and based on clinical criteria for admission and continuing stay. The anticipated duration of the service must be documented in the Individualized Treatment, Rehabilitation, and Recovery Plan.
STAFFING REQUIREMENTS	Licensed Clinicians: sufficient to meet staffing ratio All practitioners providing CPP must be certified or actively working towards certification to be a CPP provider. Practitioners must submit verification of their certification as a CPP provider prior to providing CPP services.
STAFFING RATIO	1 Therapist: 1 Family

CONTINUED STAY REQUIREMENTS	All of the following criteria must be met for continuing treatment at this level of care: • The acuity of the individual's symptoms continues to necessitate treatment at the current level of care based on admission criteria • The individual does not require a more intensive level of services and no less intensive level of care is appropriate • The individual's treatment plan is up to date, with targets that are appropriate and related to improvement in the individual's symptoms and achievement of their goals. • The individual is making progress towards rehabilitation goals and they are showing progress towards symptom reduction as demonstrated by objective behavioral measurement of functional improvement or standardized report from the member or guardian of symptom and/or functional improvement. • If progress has not been made or symptoms are increased, the treatment plan has been modified to focus on any new symptoms or to address barriers to progress. • There is evidence that the treatment team is working towards a transition plan to meet the individual's treatment needs once this level of care is no longer appropriate. • The individual and their family, guardians, or caregivers are actively participating in treatment
DESIRED INDIVIDUAL OUTCOME	• The individual has substantially met the Individualized Treatment, Rehabilitation, and Recovery Plan goals and objectives • The precipitating condition and symptoms are stabilized such that there is sustained improvement in health and psychosocial functioning • The individual's symptoms can be managed without the professional external supports and intervention at this level of care • The individual's family, guardians, or caregivers have formal and informal support systems secured to maintain the individual's stability in the community

Community Support

Community support services provide rehabilitative and support services for individuals with mental health or substance use disorder diagnoses. Community support workers provide direct rehabilitation and support services in the community with the intention of supporting the individual to maintain stable community living and preventing exacerbation of their mental illness and admission to higher levels of care.

SERVICE TYPE	Mental health, substance use disorder, or both
ALLOWABLE SETTINGS	• Community • Home • Office or Clinic
BILLING INFORMATION	Fee schedule codes for this service are: • H2015 Community Support Services - Mental Health (per 15 minutes) • H2015 HF ASAM Level 1.0 – Adult Community Support (per 15 minutes) This service may not be provided at the same service hour as other rehabilitation services. **Telehealth** For current telehealth allowances for this service, please refer to the Medicaid Mental Health and Substance Use fee schedule
ADMISSION REQUIREMENTS	• Age: 21 years of age and older – for youth eligibility, refer to EPSDT requirements as outlined in the definition section of this manual. **For mental health treatment**: • The individual demonstrates symptomatology consistent with a mental health disorder diagnosis as outlined in the current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association, which requires and can reasonably be expected to respond to therapeutic intervention • Serious mental illness as evidenced by functional limitations related to the diagnosis that seriously interfere with the individual's ability to function independently in an appropriate manner in two of three functional areas: ○ Instrumental activities of daily living: inability to be employed or an ability to be employed only with extensive supports; deterioration or decompensation resulting in inability to establish or pursue educational goals within normal time frame or without extensive supports; or inability to consistently and independently carry out home management tasks

	○ Social functioning: repeated inappropriate or inadequate social behavior or ability to behave appropriately only with extensive supports; or consistent participation in adult activities only with extensive supports or when involvement is mostly limited to special activities established for persons with mental illness; or history of dangerousness to self or others. ○ Activities of daily living: inability to consistently perform the range of practical daily living tasks required for basic adult functioning as evidenced by functional limitations in at least three of the following areas: ▪ Grooming, hygiene, washing clothes, meeting nutritional needs ▪ Care of personal business affairs ▪ Transportation and care of residence ▪ Procurement of medical, legal, and housing services ▪ Recognition and avoidance of common dangers or hazards to self and possessions **For substance use disorder treatment:** • The individual demonstrates symptomatology consistent with a substance use disorder diagnosis as outlined in the current editions of the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association, which requires and can reasonably be expected to respond to therapeutic intervention The individual meets applicable dimensional criteria for admission to this service according to the American Society of Addiction Medicine (ASAM), 4th edition criteria **For mental health or substance use disorder treatment:** • It is expected that the individual will be able to benefit from this treatment • There are significant symptoms as a result of the diagnosis that interfere with the individual's ability to function in at least one life area. • This level of care is the least restrictive setting that will produce the desired results in accordance with the needs of the individual
SERVICE EXPECTATIONS	**Assessments** • If an IDI was completed within 12 months prior to admission, and is determined to be clinically relevant, it may serve as the admission IDI. If there has been a gap in treatment of six months or more, or if there is new information available, an IDI addendum must be completed and may serve as the admission IDI • If an Initial Diagnostic Interview (IDI) has not been completed within the 12 months prior to admission, a new IDI or IDI addendum must be

	completed within 24 hours of the beginning of treatment. The IDI must meet the requirements as noted in the Initial Diagnostic Interview definition in this manual *If the individual is being treated for a substance use disorder only, a substance use disorder (SUD) assessment may be completed as a substitute for an IDI:* • If an SUD assessment was completed within 12 months prior to admission to the service, and is determined to be clinically relevant, it can serve as the service admission assessment. If there has been a gap in treatment of six months or more, or if there is new information available, an SUD addendum must be completed and may serve as the admission SUD assessment • If an SUD assessment has not been completed within the 12 months prior to admission, a new SUD assessment or addendum must be completed within 24 hours of the beginning of treatment and must establish the need for this service. The SUD assessment must meet the requirements outlined in the SUD Assessment definition in this manual • A strengths-based assessment, which may include skills inventories, interviews and/or use of other tools for the purpose of identifying treatment and rehabilitation goals and plans with the individual should be completed within 30 days of admission and may be completed by either non-licensed or licensed individuals on the individual's team **Treatment Planning** • An initial treatment plan must be developed within 24 hours of admission to guide the first 30 days of treatment • Under clinical supervision, develop an Individualized Treatment, Rehabilitation, and Recovery Plan, including discharge plan, with the individual within 30 days of admission • Review and update the Individualized Treatment, Rehabilitation, and Recovery Plan every 90 days or more often as clinically indicated. Review must be completed with the individual under the direction of a licensed clinician and must include family, guardians, other supports as authorized by the individual **Community Support Services** • Provide access to Medication Assisted Treatment (MAT) as medically appropriate • Provide active rehabilitation and support interventions that will enable the individual to reside in their community. The interventions must focus on activities of daily living, budgeting, medication adherence and self-administration, relapse prevention, social skills, and other

	independent living skills the individual is unable to complete due to symptoms of their mental health diagnosis
	• Provide assistance in accessing medical, psychiatric, psychological, social, education, housing, transportation or other appropriate treatment and support services identified in the Individualized Treatment, Rehabilitation, and Recovery Plan
	• Assist the individual with access to health care, insurance, and other social services access and navigation. This includes assisting the individual with applications for benefits, navigating eligibility issues, and ensuring that the individual understands and knows how to use benefits they receive
	• Develop and implement strategies with the individual to increase engagement in mental health or substance use disorder treatment services as appropriate
	• Maintain regular communication with the individual's treatment and rehabilitation team and treating clinician, including updates on the individual's progress and response to community support interventions
	• Provide crisis support and intervention to the individual and work with the individual to develop a crisis relapse prevention plan.
	• Provide contact as needed with other service providers, family members, or other significant people in the individual's life to support the individual in maintaining stability in the community
	• Facilitate, in cooperation with treatment providers, the individual's transition back into the community upon discharge from hospitalization, incarceration, or residential care
	
	Discharge Planning
	• Discharge planning is an ongoing process that occurs through the duration of service. A documented discharge plan must be completed as part of the Individualized Treatment, Rehabilitation, and Recovery Plan
	• A transition plan must be completed prior to discharge. A copy of the transition plan must be given to the individual and to providers at the individual's next level of care, as applicable
	• Provide the following assistance as appropriate:
	  ○ Assist individuals with identifying and accessing housing resources
	  ○ Coordinate with community resources on behalf of individuals to facilitate successful reintegration into daily activity such as work, school, or family living as appropriate
	  ○ Provide referrals and coordinate transition to a lower or higher level of care as clinically indicated

LENGTH OF SERVICE	Length of service is individualized and based on clinical criteria for admission and continuing stay. The anticipated duration of the service must be documented in the treatment, recovery, and rehabilitation plan

STAFFING	**Clinical Supervisor:** Must be one of the following: • Psychiatrist • Physician • Psychologist • Provisionally licensed psychologist • Advanced practice registered nurse (APRN) • Physician assistant (PA) • Licensed independent mental health practitioner (LIMHP) • Licensed mental health practitioner (LMHP) • Provisionally licensed mental health practitioner (PLMHP) ***If providing services for substance use only, the clinical supervisor may also be:*** • Licensed alcohol and drug counselor (LADC) • Provisionally licensed alcohol and drug counselor (PLADC) **Supervision of Community Support Providers:** The clinical supervisor must review individual clinical needs with the community support provider every 30 days. The review may be accomplished by the supervisor consulting with the community support provider and identifying clinical recommendations. The clinical supervisor may complete the review in a group setting with more than one community support provider as long as each individual on the community support provider's case load is reviewed **Community Support providers:** as needed to meet staffing ratio
STAFFING RATIO	• Community support provider to individual: 1:25 • Clinical supervisor to community support provider: 1:6
HOURS OF OPERATION	To ensure access for all individuals, providers should be able to provide services during evening and weekend hours in addition to typical business hours. Weekend and evening hours may be by appointment as appropriate for established clients if the provider is not typically open outside of business hours.
CONTINUED STAY REQUIREMENTS	All of the following criteria must be met for continuing treatment at this level of care: • The acuity of the individual's symptoms continues to necessitate treatment at the current level of care based on admission criteria • The individual does not require a more intensive level of services and no less intensive level of care is appropriate

	• The individual's treatment plan is up to date, with targets that are appropriate and related to improvement in the individual's symptoms and achievement of their goals. • The individual is making progress towards rehabilitation goals and they are showing progress towards symptom reduction as demonstrated by objective behavioral measurement of functional improvement or standardized report from the member or guardian of symptom and/or functional improvement. • If progress has not been made or symptoms are increased, the treatment plan has been modified to focus on any new symptoms or to address barriers to progress. • There is evidence that the treatment team is working towards a transition plan to meet the individual's treatment needs once this level of care is no longer appropriate.
DESIRED INDIVIDUAL OUTCOME	• The individual has substantially met the treatment, recovery, and rehabilitation plan goals and objectives • The precipitating condition and relapse potential is stabilized such that there is sustained improvement in health and psychosocial functioning • The individual's condition can be managed without the professional external supports and intervention at this level of care • The individual has alternative support systems secured to help maintain active recovery and stability in the community • The individual is connected to the next appropriate level of care necessary to treat the condition • Symptoms are increased or not improving, and no changes have been made to the treatment plan to address barriers to progress

Community Treatment Aide

Community Treatment Aid (CTA) services must be supportive, rehabilitative, and psycho-educational interventions that are provided primarily in the individual's natural environment. The CTA provider must assist the individual and caregivers in learning and rehearsing specific strategies and techniques. CTA services must help to decrease the severity of, or to eliminate symptoms and behaviors that create significant impairment in the individual's ability to function due to mental health disorders.

The intent of CTA service must be to restore the fullest possible integration of the individual as an active and productive member of their family, community, or culture with the least amount of ongoing professional intervention. CTA services must be face-to-face interventions with the individual present. Services may be provided individually and in a family setting.

SERVICE TYPE	Mental health, substance use disorder, or both
ALLOWABLE SETTINGS	• Community • Home • Office or Clinic
BILLING INFORMATION	Fee schedule code for this service is: • H0036 – Community Treatment Aide (CTA) **Telehealth** For current telehealth allowances for this service, please refer to the Medicaid Mental Health and Substance Use fee schedule
ADMISSION REQUIREMENTS	• Age: 20 years of age or younger • The individual demonstrates symptomatology consistent with a mental health diagnosis as outlined in the current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association, which requires and can reasonably be expected to respond to therapeutic intervention • It is expected that the individual will be able to benefit from this treatment • There are significant symptoms as a result of the diagnosis that interfere with the individual's ability to function in at least one life area. • This level of care is the least restrictive setting that will produce the desired results in accordance with the needs of the individual • The individual is receiving treatment by a licensed clinician for a mental health or substance use disorder diagnosis • The individual would require a more restrictive treatment environment

	without the services of a CTA
SERVICE EXPECTATIONS	**Assessments:** • If an IDI was completed within 12 months prior to admission, and is determined to be clinically relevant, it may serve as the admission IDI. If there has been a gap in treatment of six months or more, or if there is new information available, an IDI addendum must be completed and may serve as the admission IDI • If an Initial Diagnostic Interview (IDI) has not been completed within the 12 months prior to admission, a new IDI or IDI addendum must be completed within 24 hours of the beginning of treatment. The IDI must meet the requirements as noted in the Initial Diagnostic Interview definition in this manual **Treatment Planning** • An initial treatment plan must be developed within 24 hours to guide the first 30 days of treatment • Develop an Individualized Treatment, Rehabilitation, and Recovery Plan, including discharge plan and relapse prevention, with the individual (consider community, family and other supports) within 30 days of admission • Review and update the Individualized Treatment, Rehabilitation, and Recovery Plan every 90 days or more often as clinically indicated. Review must be completed under a licensed clinician with the individual and must include family, guardians, other supports as authorized by the individual **Services** The CTA must have a licensed clinical supervisor, who is providing care to the individual. The CTA and the licensed clinician must coordinate care and have documented communication at least every other week to ensure the CTA activities delivered to the individual remain relevant to the individual's Individualized Treatment, Rehabilitation, and Recovery Plan. CTA providers must provide training, rehabilitation, and education for the individual, parent or primary caregiver, which must include the following as appropriate: • Basic personal care and activities of daily living, personal grooming habits, and improved daily organization • Social skills and relationship skills to learn acceptable social

behavior to improve relationships with family members, peer groups and community
- Crisis and de-escalation techniques that assist the individual in managing emotions, understanding anger, and outlets for healthy releases of emotions
- Behavioral treatment interventions and techniques to understand and learn appropriate interactions through the use of role-playing techniques and modeling appropriate behaviors
- Appropriate coping skills to manage dysfunctional behavior by understanding and learning healthy methods to cope with stress to reduce and eliminate dysfunctional behavior
- Medication compliance, relapse prevention, and resolving medication non-compliance. The CTA provider reports medication compliance to their supervising licensed mental health practitioner

CTA service interventions include:

- Prompting the individual to recognize positive responses to emotional management techniques
- Prompting the individual when an emotional management change is necessary and demonstrate an appropriate method
- Modeling acceptable behaviors and assisting the individual through verbal cues
- Role-play scenarios with the individual using a variety of appropriate techniques in managing behavior
- Family or primary caregiver training to reinforce the interventions the individual is receiving to promote consistency

Caregiver Participation: Caregivers are essential to the generalization and ongoing maintenance of skills for individuals receiving CTA services. Participation by parents or caregivers is vital to the fidelity of CTA services. Caregiver participation is expected, and continued authorization for CTA services will take consideration of their involvement and ability to reinforce behavior changes over time and across settings. Exceptions to this general expectation may be considered on a case-by-case basis. For example: for an individual in residential placement through the Division of Child and Family Services who has a treatment plan designed to address this limitation. In these cases, persons involved in the individual's care are encouraged to be involved in implementation of the therapeutic interventions in the home and community.

CTA services will not be denied solely on the basis of lack of parent or caregiver involvement; however, parent or caregiver involvement may affect the effectiveness, durability, and generalizability to natural settings of the

treatment and may be considered when making determinations regarding effectiveness of the treatment requested. In cases where caregiver participation is not possible, providers must have documentation of how skills will be maintained upon discharge.

To support appropriate engagement, CTA providers must:

- Include goals for family involvement within the treatment plan
- Document family agreement to participate in treatment
- Assess for barriers to family engagement, and document a plan for addressing barriers
- Ensure family participation during all CTA sessions. Inability to meet this requirement must be documented and will be considered on a case-by-case basis.
- Provide weekend and evening availability for family involvement

Service Limitations

CTA services are not covered for:

- Services provided at a work site which are primarily job task oriented
- Services or components of services which supplant housekeeping, homemaking, or basic services for the convenience of a person receiving covered services (including housekeeping, shopping, childcare, and laundry services)
- Services which are used in place of a school aide or other similar services
- Services provided in an Institution for Mental Disease (IMD) or residential treatment.
- Transportation of children
- Education services: Providers must be familiar with each youth's IEP and coordinate with the youth and the youth's school to achieve the IEP. Education services may not be the primary reason for rehabilitation admission or treatment. Academic education services, when required by law, must be available.

Support Services

- Provide access to Medication Assisted Treatment (MAT) as medically appropriate
- Consultation, referral, or both for medical, psychological, and psychopharmacology needs
- Assist the individual with accessing community supports and resources. The CTA provider must provide the following assistance as appropriate:
- Coordinate with community resources on behalf of the individual

	• Assist with healthcare navigation
	• Coordinate with and facilitate access to external providers for individuals who require concurrent treatment
	• Assist individuals with application for and access to benefits and social support services
	• Assist individuals with reintegration into the community by identifying and connecting individuals with off-site vocational and educational resources
	
	Discharge Planning
	
	• Discharge planning is an ongoing process that occurs through the duration of service. A documented discharge plan must be completed as part of the individualized Treatment, Rehabilitation, and Recovery Plan
	• A transition plan must be completed prior to discharge. A copy of the transition plan must be given to the individual and to providers at the individual's next level of care, as applicable
	• The CTA provider must assist individuals with transition and discharge planning. The CTA provider must:
	  • Assist individuals with identifying and accessing housing resources if being discharged to independent living
	  • Coordinate with community resources on behalf of individuals to facilitate successful reintegration into daily activity such as work, school, or family living as appropriate
	  • Provide referrals and coordinate transition to a lower or higher level of care as clinically indicated

LENGTH OF SERVICE	Length of service is individualized and based on clinical criteria for admission and continuing stay. The anticipated duration of the service must be documented in the Individualized Treatment, Rehabilitation, and Recovery Plan
STAFFING	**Clinical Supervisor:** Must be one of the following: • Psychiatrist • Physician • Psychologist • Provisionally licensed psychologist • Advanced practice registered nurse (APRN) • Physician Assistant (PA) • Licensed Independent Mental Health Practitioner (LIMHP) • Licensed mental health practitioner (LMHP)

	• Provisionally licensed mental health practitioner (PLMHP) **Community Treatment Aide Staff:** • **Community Treatment Aide**
STAFFING RATIO	• Community treatment aide staff to individual: 1:25 • Clinical supervisor to community treatment aide staff: 1:6
HOURS OF OPERATION	To ensure access for all individuals, providers should be able to provide services during evening and weekend hours in addition to typical business hours. Weekend and evening hours may be by appointment as appropriate for established clients if the provider is not typically open outside of business hours.
CONTINUED STAY REQUIREMENTS	All of the following criteria must be met for continuing treatment at this level of care: • The acuity of the individual's symptoms continues to necessitate treatment at the current level of care based on admission criteria • The individual does not require a more intensive level of services and no less intensive level of care is appropriate • The individual's treatment plan is up to date, with targets that are appropriate and related to improvement in the individual's symptoms and achievement of their goals. • The individual is making progress towards rehabilitation goals and they are showing progress towards symptom reduction as demonstrated by objective behavioral measurement of functional improvement or standardized report from the member or guardian of symptom and/or functional improvement. • If progress has not been made or symptoms are increased, the treatment plan has been modified to focus on any new symptoms or to address barriers to progress. • There is evidence that the treatment team is working towards a transition plan to meet the individual's treatment needs once this level of care is no longer appropriate.
DESIRED INDIVIDUAL OUTCOME	• The individual meets the goals and objectives of the Individualized Treatment, Rehabilitation, and Recovery Plan • The precipitating condition has stabilized such that the individual's condition can be managed with decreased professional supports and interventions • The individual is referred to ongoing treatment services as clinically indicated • The individual has support systems in place to help the individual

	maintain stability in the community • The individual's parents or caregivers understand how to access supports to maintain wellness and stability for the individual and the family unit in the community

Electroconvulsive Therapy (ECT)

Electroconvulsive Therapy (ECT) is a treatment where an electric current, which is medically controlled, is applied to one or both sides of the brain for the purpose of producing a seizure that is modulated by anesthesia and muscle relaxants in order to provide relief from severe, acute, and debilitating symptoms of a psychiatric disorder.

SERVICE TYPE	Mental health
SETTING	Electroconvulsive Therapy (ECT) can be administered in: • Inpatient setting • Outpatient setting in a facility with treatment and recovery rooms The setting must be equipped with the following: • Medications and equipment for cardiac resuscitation, including a defibrillator • Oxygen administration equipment, ranging from a nasal cannula to a nonrebreather mask • Suction device • Airway equipment, including a bag-valve mask, laryngeal mask airway, bougie, direct or video-assisted laryngoscopy with appropriate blades, and appropriately sized oral airway and endotracheal tubes; surgical and needle airway equipment should also be available • Reversal agents, including naloxone and flumazenil • Monitoring equipment, including a cardiac monitor, blood pressure cuff, pulse oximeter, and end-tidal carbon dioxide monitor
BILLING INFORMATION	Fee schedule code for this service is: • 90870 – Electroconvulsive Therapy – ECT (includes necessary monitoring) **Telehealth** This service must be provided in person.
ADMISSION REQUIREMENTS	• Age: 21 years of age and older – for youth eligibility, refer to EPSDT requirements as outlined in the definition section of this manual. • The individual has been unresponsive to trials of effective medications of adequate dose and duration that are indicated for the individual's condition e.g., anti-depressants, anti-psychotics • The individual is unable to tolerate effective medications or has a medical condition for which medication is contraindicated • The individual has had favorable responses to ECT in the past, and rapid response symptom alleviation is medically necessary

	• The individual is unable to safely wait until medication is effective e.g., due to life- threatening conditions, psychosis, stupor, extreme agitation, high suicide or homicide risk • Individual is experiencing severe mania or depression during pregnancy • Individual and the psychiatrist have agreed that ECT is the least restrictive treatment to effectively treat acute and persistent symptoms • The individual has been provided education on the risks and benefits of ECT and consents to treatment

SERVICE EXPECTATIONS	**Assessments**:
	• An Initial Diagnostic Interview (IDI) must be completed within 24 hours of the beginning of treatment. The IDI must meet the requirements as noted in the Initial Diagnostic Interview definition in this manual
	  • If an IDI was completed within 12 months prior to admission, and is determined to be clinically relevant, it may serve as the admission IDI. If there has been a gap in treatment of six months or more, or if there is new information available, an IDI addendum must be completed and may serve as the admission IDI
	• An ECT-specific physical examination by a psychiatrist, physician, APRN, or PA must be completed within 30 days prior to starting treatment interventions. The exam must include:
	  • Medical history, including history of past ECT treatment and response
	  • Neurological, cardiovascular and pulmonary evaluation
	  • Previous medications prescribed to treat mental health or substance use symptoms and response
	  • Current medications
	  • Dental status
	  • Review of any laboratory tests including electrocardiogram completed within the 30 days prior to initiation of ECT
	• An anesthesia evaluation by an anesthesiologist or CRNA must be completed within 48 hours prior to starting treatment interventions. The evaluation must include:
	  • Prior anesthesia inductions, the individual's response, and any complications
	  • Any current anesthesia risks
	  • Development of an anesthesia plan of care, including medications and anesthesia technique
	• An ECT clinical summary must be completed prior to starting treatment interventions. The summary must include:

	• The admission IDI • The ECT physical assessment • The anesthesia evaluation and anesthesia plan of care • Clinical justification of the need for ECT, including past treatments attempted and response • Current functioning level **Treatment Planning** • An individualized ECT treatment plan must be developed prior to treatment that includes all of the following: • Specific medications to be administered during ECT • Choice of electrode placement during ECT • Stimulus dosing using a recognized method to produce an adequate seizure while minimizing adverse cognitive side effects • Plan to achieve sustained remission of symptoms with lowest number of ECTs necessary **Clinical Services** • During the administration of ECT the following must be monitored: • Seizure duration, including missed, brief or prolonged seizures, or lack of attaining desired seizure activity • Electroencephalographic activity • Vital signs • Pulse Oximetry • Cardiovascular effects • Respiratory effects, including any prolonged apnea • Other monitoring specific to the needs of the individual. • After the administration of ECT, stabilization and recovery care must include: • Medically supervised care by the anesthesia provider in the treatment room until vital signs, cardiovascular, and respiratory function have stabilized • Observation that no adverse effects such as headache, muscle soreness and nausea are present • Ongoing medically supervised care by the anesthesia provider in the recovery room with continuous nursing care, monitoring of vital signs, cardiovascular, and respiratory function, pulse oximetry, and ECG if indicated **Support Services** • Consultation, referral, or both for medical, psychological, mental health or substance use treatment, and psychopharmacology needs • Coordinate care with the individual's primary medical provider and other treating professionals

	• Co-occurring mental health or substance use disorder conditions that are stable must be monitored • All services must be provided with cultural competence • Crisis assistance must be available 24 hours a day, 7 days a week
LENGTH OF SERVICE	Length of service is individualized based on the individual's response to ECT
STAFFING	ECT may be administered by: • Psychiatrist • Physician • APRN Anesthesia may be administered by: Anesthesiologist (CRNA)
STAFFING RATIO	Medical provider to individual 1:1
HOURS OF OPERATION	To ensure access for all individuals, providers should be able to provide services during evening and weekend hours in addition to typical business hours. Weekend and evening hours may be by appointment as appropriate for established clients if the provider is not typically open outside of business hours.
CONTINUED STAY REQUIREMENTS	All of the following criteria must be met for continuing treatment at this level of care: • The acuity of the individual's symptoms continues to necessitate treatment at the current level of care based on admission criteria • The individual does not require a more intensive level of services and no less intensive level of care is appropriate • The individual's treatment plan is up to date, with targets that are appropriate and related to improvement in the individual's symptoms and achievement of their goals. • The individual is making progress towards rehabilitation goals and they are showing progress towards symptom reduction as demonstrated by objective behavioral measurement of functional improvement or standardized report from the member or guardian of symptom and/or functional improvement. • If progress has not been made or symptoms are increased, the treatment plan has been modified to focus on any new symptoms or to address barriers to progress. • There is evidence that the treatment team is working towards a transition plan to meet the individual's treatment needs once this level of care is no longer appropriate. • Despite reasonable therapeutic efforts, clinical findings indicate at least one of the following:

	○ Persistence or emergence of new symptoms for which ECT is considered appropriate as outlined in the Admission Requirements ○ Attempts to discharge to a less-intensive treatment will or can be reasonably expected, based on individual history or clinical findings, to result in exacerbation or worsening of the individual's condition ▪ Continuation and maintenance ECT should be based on clinical status based on self-report and clinician-administered rating scales ▪ Continuation schedule should be adjusted to the needs of the patient, taking into account the patient's history of relapse and the severity of prior depressive episodes ○ Robust medication management has not been efficacious in stabilizing symptoms without the addition of ECT
DESIRED INDIVIDUAL OUTCOME	• Stabilization or resolution of psychiatric symptoms for which ECT was intended as an intervention • The precipitating condition and symptoms are stabilized such that there is sustained improvement in health and psychosocial functioning • The individual's symptoms can be managed without the intervention at this level of care

Functional Family Therapy

Functional Family Therapy (FFT) for youth aged 20 or younger is a psychotherapy intervention primarily for youth 11 to 18 years of age who have been referred to behavioral or emotional problems by juvenile justice, mental health, school, or child welfare systems. FFT can be provided in clinics and home settings, and can also be provided in schools, aftercare systems, probation and parole offices, child welfare facilities and mental health facilities.

The three core principles of FFT are:

- Understanding the individual
- Understanding the individual systemically
- Understanding psychotherapy and the role of the therapist as a fundamentally relational process

The FFT clinical model concentrates on decreasing risk factors and on increasing protective factors that directly affect adolescents, with a particular emphasis on familial factors.

SERVICE TYPE	• Mental health, substance use disorder, or both
ALLOWABLE SETTINGS	• Community • Home • Office or Clinic
BILLING INFORMATION	Fee schedule codes for this service are: Individual Functional family therapy: • 90832 U9 - Functional family therapy (30 minutes) • 90834 U9 - Functional family therapy (45 minutes) • 90837 U9 - Functional family therapy (60 minutes) Family Functional family therapy: • 90846 U9 - Functional family therapy, Individual Not Present • 90847 U9 - Functional family therapy with Individual Present **Telehealth** For current telehealth allowances for this service, please refer to the Medicaid Mental Health and Substance Use fee schedule
ADMISSION CRITERIA	• Age: 11 to 18 years of age. ○ Individuals outside of this age range who are aged 20 or younger may be approved for services if clinical justification is submitted for prior authorization and approved

	• The individual demonstrates symptomatology consistent with a mental health or substance use disorder diagnosis as outlined in the current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association, which requires and can reasonably be expected to respond to therapeutic intervention • The individual has been referred to the provider for behavioral or emotional problems by the juvenile justice, mental health, school, or child welfare systems • The individual is justice involved or is at risk for delinquency, violence, or substance use behaviors • There are significant symptoms as a result of the diagnosis that interfere with the individual's ability to function in at least one life area. • Of all reasonable options available to the individual, this service is the best treatment option with expectation of improvement in the individual's behavioral functioning • FFT is required for reasons other than primarily for the convenience of the individual or the provider. • FFT is identified in the treatment plan as a treatment intervention for the individual
SERVICE REQUIREMENTS	**Assessments:** • Prior to FFT services, a medical evaluation must be performed by a physician or APRN to rule out any medical conditions which may cause or contribute to the child's behavior • A family assessment must be performed at the onset of FFT. The family assessment must meet the requirements as noted in this document • If an IDI was completed within 12 months prior to admission, and is determined to be clinically relevant, it may serve as the admission IDI. If there has been a gap in treatment of six months or more, or if there is new information available, an IDI addendum must be completed and may serve as the admission IDI. • If an Initial Diagnostic Interview (IDI) has not been completed within the 12 months prior to admission, a new IDI or IDI addendum must be completed within 24 hours of the beginning of treatment. The IDI must meet the requirements as noted in the Initial Diagnostic Interview definition in this manual **Treatment Planning** • An initial treatment plan must be developed within 24 hours of admission to guide the first 30 days of treatment • Under clinical supervision, develop an Individualized Treatment, Rehabilitation, and Recovery Plan, including discharge plan, with the individual within 30 days of admission

	• Review and update the Individualized Treatment, Rehabilitation, and Recovery Plan every 90 days or more often as clinically indicated. Review must be completed with the individual under the direction of a licensed clinician and must include family, guardians, other supports as authorized by the individual **Clinical Services** • Services must follow FFT clinical protocols and best practices, and must be tailored to each individual's level of clinical severity and designed to help the individual achieve changes in their symptoms • Provide training to the individual and their family, guardian, or caregivers in socially acceptable behaviors via modeling, prompting, roleplaying, and reinforcement of appropriate behaviors to promote consistency for the individual • Services must involve the child and their family, guardian, or caregivers for the purpose of changing behavior, focusing on the level of family functioning as a whole and addressing issues related to the entire family system • During the therapy process, collaborative, person-focused progress tracking should be supported by periodic collection of objective behavioral indicators of functional status and/or standardized reports of symptom burden and functional status from the individual or their guardian. Reviewing these measures and their patterns over time directly with the individual or guardian helps ensure care remains aligned with their goals, supports shared decision-making, and promotes meaningful progress toward improved well-being. • The goals, frequency, and duration of treatment will vary according to individual needs and response to treatment **Support Services** • Provide access to Medication Assisted Treatment (MAT) as medically appropriate • Provide consultation, referral, or both for medical, psychological, and psychopharmacology needs • Assessments, treatment, and referral must address co-occurring needs • It is the provider's responsibility to coordinate with other treating professionals **Discharge Planning** • Discharge planning is an ongoing process that occurs through the duration of service. A documented discharge plan must be completed as part of the Individualized Treatment, Rehabilitation, and Recovery Plan • A transition plan must be completed prior to discharge. A copy of the transition plan must be given to the individual and to providers at the individual's next level of care, as applicable

STAFFING REQUIREMENTS	**FFT Clinical Supervisor** Must be one of the following: • Psychiatrist • Physician • Psychologist • Provisionally licensed psychologist • Advanced practice registered nurse (APRN) • Physician Assistant (PA) • Licensed Independent Mental Health Practitioner (LIMHP) • Licensed Mental Health Practitioner (LMHP) **FFT Treatment Provider** • FFT treatment providers must be licensed clinicians as defined in this document, operating within their professional competencies • All FFT treatment providers must have a master's degree or greater and must be a member of an active FFT team **Additional Requirements** FFT treatment providers and clinical supervisors must be certified in the FFT model, as defined by FFT LLC.
STAFFING RATIO	The FFT team must include one FFT certified clinical supervisor and at least three FFT certified treatment providers. Staffing must be adequate to meet the treatment needs of the individual and to meet the responsibilities of each FFT team member as outlined in the FFT model.
CONTINUED STAY REQUIREMENTS	All of the following criteria must be met for continuing treatment at this level of care: • The acuity of the individual's symptoms continues to necessitate treatment at the current level of care based on admission criteria • The individual does not require a more intensive level of services and no less intensive level of care is appropriate • The individual's treatment plan is up to date, with targets that are appropriate and related to improvement in the individual's symptoms and achievement of their goals. • The individual is making progress towards rehabilitation goals and they are showing progress towards symptom reduction as demonstrated by objective behavioral measurement of functional improvement or standardized report from the member or guardian of symptom and/or functional improvement.

	• If progress has not been made or symptoms are increased, the treatment plan has been modified to focus on any new symptoms or to address barriers to progress. • There is evidence that the treatment team is working towards a transition plan to meet the individual's treatment needs once this level of care is no longer appropriate. • There is documented evidence that continuation of FFT services is necessary to regain family functioning • The individual's family are actively participating in treatment as clinically appropriate, or there are active, persistent efforts being made to engage them in treatment • FFT is rendered in a clinically appropriate manner and focused on the family's behavioral and functional outcomes as described in the Individualized Treatment, Rehabilitation, and Recovery Plan
DESIRED INDIVIDUAL OUTCOME	• The individual has substantially met the treatment, recovery, and rehabilitation plan goals and objectives • The individual and family have support systems secured to help maintain stability in the community • The specific issue that initially brought the individual into FFT has improved or resolved and FFT is no longer necessary for the wellbeing of the individual • There are fewer incidences of disruptive behavior in the home • Positive family interactions and conflict resolution skills have increased • The individual is connected to the next appropriate level of care necessary to treat the condition

Medication Management

Medication Management is the evaluation of the individual's need for psychotropic medications, provision of a prescription, and ongoing medical monitoring of those medications

<table>
<tr><td>SERVICE CATEGORY</td><td>Mental health or substance use disorder, or both</td></tr>
<tr><td>ALLOWABLE SETTINGS</td><td>Community
Home
Office or Clinic
Emergency Room
Hospital</td></tr>
<tr><td>BILLING INFORMATION</td><td>Medication management is billed using appropriate evaluation and management (E/M) visit codes. E/M coding must follow American Medical Association and CMS criteria for E/M visits.

Fee schedule codes for this service are:

<table>
<tr><td>98966</td><td>99214</td><td>99283</td><td>99341</td></tr>
<tr><td>98967</td><td>99215</td><td>99284</td><td>99342</td></tr>
<tr><td>98968</td><td>99221</td><td>99285</td><td>99344</td></tr>
<tr><td>99202</td><td>99222</td><td>99304</td><td>99345</td></tr>
<tr><td>99203</td><td>99223</td><td>99305</td><td>99347</td></tr>
<tr><td>99204</td><td>99231</td><td>99306</td><td>99348</td></tr>
<tr><td>99205</td><td>99232</td><td>99307</td><td>99349</td></tr>
<tr><td>99211</td><td>99233</td><td>99308</td><td>99350</td></tr>
<tr><td>99212</td><td>99281</td><td>99309</td><td></td></tr>
<tr><td>99213</td><td>99282</td><td>99310</td><td></td></tr>
</table>

90792 is billable for this service when provided in accordance with this definition as well as the requirements for Initial Diagnostic Interviews as described in this manual.

Provider types which are allowed to bill for these services are outlined in the Mental Health and Substance Use Fee Schedule.</td></tr>
</table>

	Telehealth For current telehealth allowances for this service, please refer to the Medicaid Mental Health and Substance Use fee schedule
ADMISSION REQUIREMENTS	• Age: Any • The individual demonstrates symptomatology consistent with a diagnosis as outlined in the current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association, which requires and can reasonably be expected to respond to therapeutic intervention • There are significant symptoms that interfere with the individual's ability to function in at least one life area • There is an expectation that the individual has the capacity to make significant progress
SERVICE EXPECTATIONS	**Assessments** • If an IDI was completed within 12 months prior to admission, and is determined to be clinically relevant, it may serve as the admission IDI. If there has been a gap in treatment of six months or more, or if there is new information available, an IDI addendum must be completed and may serve as the admission IDI • If an Initial Diagnostic Interview (IDI) has not been completed within the 12 months prior to admission, a new IDI or IDI addendum must be completed within 24 hours of the beginning of treatment. The IDI must meet the requirements as noted in the Initial Diagnostic Interview definition in this manual *If the individual is being treated for a substance use disorder only, a substance use disorder (SUD) assessment may be completed as a substitute for an IDI:* • If an SUD assessment was completed within 12 months prior to admission to the service, and is determined to be clinically relevant, it can serve as the service admission assessment. If there has been a gap in treatment of six months or more, or if there is new information available, an SUD addendum must be completed and may serve as the admission SUD assessment • If an SUD assessment has not been completed within the 12 months prior to admission, a new SUD assessment or addendum must be completed within 24 hours of the beginning of treatment and must establish the need for this service. The SUD assessment must meet the requirements outlined in the SUD Assessment definition in this manual

	• Perform or refer for physical examination if the individual has not had a physical exam within the past 12 months. The exam must be completed by a physician or APRN within 14 days of admission or sooner if indicated **Clinical Services** • Medication prescribing as clinically indicated • Medication evaluation and documentation of monitoring • Medication monitoring routinely and as needed • Education pertaining to the medication to support the individual, or parent or guardian as appropriate, in making an informed decision for its use **Support Services** • Provide access to Medication Assisted Treatment (MAT) as medically appropriate • Consultation, referral, or both for medical, psychological, mental health or substance use treatment, and psychopharmacology needs • Coordinate care with the individual's primary medical provider and other treating professionals • Co-occurring mental health or substance use disorder conditions that are stable must be monitored
LENGTH OF SERVICE	Services may continue as long as the individual continues to meet clinical criteria for admission.
STAFFING	**Licensed Clinicians:** • Psychiatrist • Physician • Advanced practice registered nurse (APRN) • Physician Assistant (PA)
STAFFING RATIO	Licensed clinician: individual 1:1
HOURS OF OPERATION	To ensure access for all individuals, providers should be able to provide services during evening and weekend hours in addition to typical business hours. Weekend and evening hours may be by appointment as appropriate for established clients if the provider is not typically open outside of business hours.

CONTINUED STAY REQUIREMENTS	• The acuity of the individual's symptoms continues to necessitate treatment at the current level of care based on admission criteria • If the individual has additional symptoms or existing symptoms are increased, medications have been reviewed and adjusted as clinically appropriate
DESIRED INDIVIDUAL OUTCOME	• Stabilization or resolution of psychiatric symptoms for which medication was intended as an intervention • The precipitating condition and symptoms are stabilized such that there is sustained improvement in health and psychosocial functioning

Multisystemic Therapy

Multisystemic Therapy (MST) is an evidenced-based, time-limited, intensive family and community-based treatment that focuses on multiple determinants of serious anti-social behavior in youth with mental health or substance use disorders and justice system involvement. MST works in the youth's natural environment to address the factors associated with delinquency across youth's key settings or systems and uses the strengths of each system to foster positive change.

SERVICE TYPE	Mental health, substance use disorder, or both
ALLOWABLE SETTINGS	• Community • Home • Office or Clinic
BILLING INFORMATION	Fee schedule code for this service is: • H2033 Multi Systemic Therapy (MST) – clinical services (per 15 minutes) MST services involving clinical contact should be billed using H2033. Clinical contact involves initial diagnostic interviews, family assessments, and individual and family psychotherapy. Multisystemic Therapy Services involving non-clinical contact (MST conferences) should be billed using H2033 with the 52 modifier. MST conferences involve collateral and telephone contacts that coordinate care and share clinical information about the individual with the parents, legal guardians or other involved parties. MST conferences must be documented, must focus on specific treatment goals, and must be part of an active treatment intervention and not simply an exchange of information between the provider, caregiver(s) or other involved parties. MST conferences may be provided without prior authorization but must otherwise follow the requirements outline in NAC Title 471, Chapter 32, section 32-002.18. Activities that may not be billed include supervision, staff meetings, court appearances, scheduling appointments, text messages, reports on individual progress, and time spent on outreach to families or individuals when "no shows" occur or to increase engagement with treatment. **Telehealth** For current telehealth allowances for this service, please refer to the Medicaid Mental Health and Substance Use fee schedule

ADMISSION REQUIREMENTS	• Age: 12-17
	  ○ Individuals outside of this age range who are aged 20 or younger may be approved for services if clinical justification is submitted for prior authorization and approved
	• All of the following guidelines are required must be met:
	  ○ Externalizing behavior symptoms such as chronic or violent juvenile offenses, resulting in a Diagnostic and Statistical Manual (DSM), current edition, diagnosis of conduct disorder or other diagnoses consistent with such symptomatology (ODD, Behavior Disorder NOS, etc.)
	  ○ The individual is at risk for out-of-home placement or is transitioning back from an out-of- home setting
	  ○ Ongoing multiple system involvement due to high-risk behaviors or risk of failure in mainstream school settings due to behavioral problems, and
	  ○ Less intensive treatment has been ineffective or is inappropriate
	• At least one of the following must be met in addition to the guidelines listed above:
	  ○ The individual has behavioral health issues that manifest in outward behaviors that negatively impact multiple systems e.g., family, school, community, or
	  ○ Individuals with substance use disorders may be included if they meet the guidelines listed above, and MST is deemed clinically more appropriate than focused drug and alcohol treatment
	• Exclusion Criteria (Any one of the following exclusion criteria are sufficient to exclude the individual from this level of care):
	  ○ The individual meets criteria for out-of-home placement due to suicidal, homicidal, or psychotic behavior
	  ○ The individual has severe and serious psychiatric problems, or was referred for primary psychiatric problems
	  ○ The individual is living independently, or a primary caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends and other potential surrogate caregivers
	  ○ The individual has symptomatology which is limited to serious sexual misbehavior
	  ○ The individual has an autism spectrum diagnosis

SERVICE EXPECTATIONS	**Assessments** • If an IDI was completed within 12 months prior to admission, and is determined to be clinically relevant, it may serve as the admission IDI. If there has been a gap in treatment of six months or more, or if there is

	new information available, an IDI addendum must be completed and may serve as the admission IDI • If an Initial Diagnostic Interview (IDI) has not been completed within the 12 months prior to admission, a new IDI or IDI addendum must be completed within 24 hours of the beginning of treatment. The IDI must meet the requirements as noted in the Initial Diagnostic Interview definition in this manual *If the individual is being treated for a substance use disorder only, a substance use disorder (SUD) assessment may be completed as a substitute for an IDI:* • If an SUD assessment was completed within 12 months prior to admission to the service, and is determined to be clinically relevant, it can serve as the service admission assessment. If there has been a gap in treatment of six months or more, or if there is new information available, an SUD addendum must be completed and may serve as the admission SUD assessment • If an SUD assessment has not been completed within the 12 months prior to admission, a new SUD assessment or addendum must be completed within 24 hours of the beginning of treatment and must establish the need for this service. The SUD assessment must meet the requirements outlined in the SUD Assessment definition in this manual **Treatment Planning** • An initial treatment plan must be developed within 24 hours to guide the first 30 days of treatment • Develop an Individualized Treatment, Rehabilitation, and Recovery Plan, including discharge plan and relapse prevention, with the individual (consider community, family and other supports) within 30 days of admission • Review and update the Individualized Treatment, Rehabilitation, and Recovery Plan every 90 days or more often as clinically indicated. Review must be completed under a licensed clinician with the individual and must include family, guardians, other supports as authorized by the individual • Services must include collateral contacts with authorized family, other involved individuals in the neighborhood, social, educational, and vocational environments, as well as those from the criminal justice, individual welfare, health and mental health systems. Collateral contacts are considered an essential component of the individual's Individualized Treatment, Rehabilitation, and Recovery plan but are not reimbursable.

Clinical Services

- The MST team must attempt face to face contact with the family within 24 hours of referral to MST
- Services must follow MST protocols and best practices, and must be tailored to each individual's level of clinical severity and designed to help the individual achieve changes in their symptoms
- The goals, frequency, and duration of treatment will vary according to individual needs and response to treatment
- The MST team must work in collaboration with the individual and family to identify and document problems throughout the family and community systems (peers, school, neighborhood, etc.) that need to be targeted for change in the Individualized Treatment, Rehabilitation, and Recovery plan
- Based on the Individualized Treatment, Rehabilitation, and Recovery plan, provide goal-directed MST services. The amount, frequency, and intensity of services must be appropriate to individual needs and level of function as determined by clinical assessment. Interventions must include:
    - Individual and family therapy
    - Parenting education and skill development
    - Assistance with accessing community resources
    - Coordination of care with authorized family, other involved individuals in the neighborhood, social, educational, and vocational environments, as well as those from the criminal justice, individual welfare, health and mental health systems
- During the therapy process, collaborative, person-focused progress tracking should be supported by periodic collection of objective behavioral indicators of functional status and/or standardized reports of symptom burden and functional status from the individual or their guardian. Reviewing these measures and their patterns over time directly with the individual or guardian helps ensure care remains aligned with their goals, supports shared decision-making, and promotes meaningful progress toward improved well-being

Support Services

- Provide access to Medication Assisted Treatment (MAT) as medically appropriate
- Provide access to a Physician or APRN for a physical exam as clinically indicated
- Provide consultation, referral, or both for medical, psychological, and psychopharmacology needs
- Assist the individual with accessing community supports and resources. The program must provide the following assistance as appropriate:
    - Coordinate with community resources on behalf of the individual

	• Assist with healthcare navigation • Coordinate with and facilitate access to external providers for individuals who require concurrent treatment • Assist individuals with application for and access to benefits and social support services • Assist individuals with reintegration into the community by identifying and connecting individuals with off-site vocational and educational resources • Peer support services may be provided but are not required **Discharge Planning** • Discharge planning is an ongoing process that occurs through the duration of service. A documented discharge plan must be completed as part of the Individualized Treatment, Rehabilitation, and Recovery Plan • A transition plan must be completed prior to discharge. A copy of the transition plan must be given to the individual and to providers at the individual's next level of care, as applicable • The program must assist individuals with transition and discharge planning. The program must: • Assist individuals with identifying and accessing housing resources if being discharged to independent living • Coordinate with community resources on behalf of individuals to facilitate successful reintegration into daily activity such as work, school, or family living as appropriate • Provide referrals and coordinate transition to a lower or higher level of care as clinically indicated
LENGTH OF SERVICE	Length of service is individualized and based on clinical criteria for admission and continuing stay as well as the individual's ability to make progress on individual goals. The anticipated duration of the service must be documented in the Individualized Treatment, Rehabilitation, and Recovery Plan. MST services are intensive and time-limited, and the duration of treatment may not exceed 5 months. Additional treatment beyond 5 months may be requested in certain clinical circumstances for which clinical justification must be submitted for prior authorization and be approved.
STAFFING	**MST Supervisor** MST supervisor must be one of the following: • Psychiatrist • Physician • Psychologist • Licensed Independent Mental Health Practitioner (LIMHP)

	All clinical supervisors will be trained in the MST model, with experience in the practice in behavioral and cognitive behavioral therapies and pragmatic family therapies i.e., Structural Family Therapy and Strategic Family Therapy. The supervisor must track progress and outcomes on each case by completing MST case paperwork and participating in team clinical supervision and MST consultation weekly **MST Therapists** MST Therapists must be licensed clinicians as defined in this document, sufficient to meet staffing ratio. Bachelor's level staff may not serve as an MST therapist. MST therapists must be dedicated to the MST program solely and have no other agency responsibilities Non-licensed master and bachelor's level providers may not provide clinical services. All non-licensed providers must be supervised by a licensed master's level practitioner for any support activities
STAFFING RATIO	**MST Team:** An active MST team requires one MST trained clinical supervisor and two to four MST therapists. **MST Clinical Supervisor:** • 50% FTE per MST team supervised • If the MST supervisor is supervising one team, and also serves as an MST treatment provider, they must be full-time. **MST Therapist** 1 MST Therapist: 6 families All staffing must be adequate to meet the individualized treatment needs of the individual and meet the responsibilities of each staff position as outlined in the MST model.
HOURS OF OPERATION	To ensure access for all individuals, providers should be able to provide services during evening and weekend hours in addition to typical business hours. Weekend and evening hours may be by appointment as appropriate for established clients if the provider is not typically open outside of business hours. An on-call system must be available 24 hours a day, 7 days a week to provide coverage when the designated MST treatment provider is unavailable. This system must be staffed by MST treatment providers or supervisors who are familiar with the details of each MST case

CONTINUED STAY REQUIREMENTS	All of the following criteria must be met for continuing treatment at this level of care: • The acuity of the individual's symptoms continues to necessitate treatment at the current level of care based on admission criteria • The individual does not require a more intensive level of services and no less intensive level of care is appropriate • The individual's treatment plan is up to date, with targets that are appropriate and related to improvement in the individual's symptoms and achievement of their goals. • The individual is making progress towards rehabilitation goals and they are showing progress towards symptom reduction as demonstrated by objective behavioral measurement of functional improvement or standardized report from the member or guardian of symptom and/or functional improvement. • If progress has not been made or symptoms are increased, the treatment plan has been modified to focus on any new symptoms or to address barriers to progress. • There is evidence that the treatment team is working towards a transition plan to meet the individual's treatment needs once this level of care is no longer appropriate. • The family is actively involved in treatment as clinically appropriate, or there are active, persistent efforts being made to engage them in treatment
DESIRED INDIVIDUAL OUTCOME	• The individualized treatment, rehabilitation, and recovery plan goals have been substantially met, including discharge plan • The individual no longer meets admission criteria, or meets criteria for a less or more intensive level of care

Opioid Treatment Program

An Opioid Treatment Program (OTP) offers community-based outpatient addiction treatment, compliant with federal regulations for individuals diagnosed with an opioid use disorder (OUD) as defined in the Diagnostic and Statistical Manual (DSM), current edition, and meeting American Society of Addiction Medicine (ASAM) criteria, current edition, for placement in an OTP, as determined by the Licensed Diagnosing practitioner. Opioid Treatment Programs administer medications approved by the Food and Drug Administration (FDA) to treat opioid use disorder and the alleviation of the adverse medical, psychological, or physical effects of opioid addiction. Medications are provided in conjunction with rehabilitative and medical services

OTP clinics must be licensed as a pharmacy in the state of Nebraska, and must follow all relevant state and federal laws for administering opioid medications.

<table>
<tr><td>SERVICE CATEGORY</td><td>Substance use disorder</td></tr>
<tr><td>ALLOWABLE SETTINGS</td><td>May be provided in the following settings:
Office or Clinic</td></tr>
<tr><td>BILLING INFORMATION</td><td>Opioid Treatment Program services are billed the HCPCS codes listed below. Billing must follow American Medical Association and CMS criteria for Opioid Treatment Programs.

Fee schedule codes for this service are:

<table><tr><td>G1028</td><td>G2074</td><td>G2079</td></tr><tr><td>G2067</td><td>G2075</td><td>G2080</td></tr><tr><td>G2068</td><td>G2076</td><td>G2215</td></tr><tr><td>G2069</td><td>G2077</td><td>G2216</td></tr><tr><td>G2073</td><td>G2078</td><td></td></tr></table>
Telehealth
For current telehealth allowances for this service, please refer to the Medicaid Mental Health and Substance Use fee schedule</td></tr>
<tr><td>ADMISSION REQUIREMENTS</td><td>The individual meets the diagnostic criteria for opioid use disorder, as defined in the Diagnostic and Statistical Manual (DSM), current edition
The individual meets applicable dimensional criteria for admission to this service according to the American Society of Addiction Medicine (ASAM), 4th edition criteria</td></tr>
</table>

	• It is expected that the individual will be able to benefit from this treatment • This level of care is the least restrictive setting that will produce the desired results in accordance with the needs of the individual
SERVICE EXPECTATIONS	**Assessments** • Physical health assessment: includes medical history, physical examination and toxicology screen. This must be completed by a physician, physician assistant (PA), or advance practice registered nurse (APRN) within the first 24 hours of an individual's admission to the program. A physical exam helps identify withdrawal symptoms. Drug and alcohol screens may be administered to identify substances present in the individual's body. Other relevant medical conditions may also be investigated • If the program physician, PA, or APRN determines upon examination that the individual has symptoms suggestive enough to warrant a provisional substance use disorder diagnosis, but is not capable of completing the initial diagnostic interview or substance use disorder assessment during the first 24 hours due to significant medical or withdrawal symptoms, the IDI or SUD assessment may be deferred but must be completed within 48 hours of admission • If an IDI was completed within 12 months prior to admission, and is determined to be clinically relevant, it may serve as the admission IDI. If there has been a gap in treatment of six months or more, or if there is new information available, an IDI addendum must be completed and may serve as the admission IDI. • If an Initial Diagnostic Interview (IDI) has not been completed within the 12 months prior to admission, a new IDI or IDI addendum must be completed within 24 hours of the beginning of treatment. The IDI must meet the requirements as noted in the Initial Diagnostic Interview definition in this manual *If the individual is being treated for a substance use disorder only, a substance use disorder (SUD) assessment may be completed as a substitute for an IDI:* • If an SUD assessment was completed within 12 months prior to admission to the service, and is determined to be clinically relevant, it can serve as the service admission assessment. If there has been a gap in treatment of six months or more, or if there is new information available, an SUD addendum must be completed and may serve as the admission SUD assessment • If an SUD assessment has not been completed within the 12 months prior to admission, a new SUD assessment or addendum must be completed within 24 hours of the beginning of treatment and must establish the need for this service. The SUD assessment must meet

	the requirements outlined in the SUD Assessment definition in this manual
	
	Treatment Planning
	
	• An initial treatment plan must be developed within 24 hours of admission to guide the first 30 days of treatment
	• Under medical supervision, develop an Individualized Treatment, Rehabilitation, and Recovery Plan, including discharge plan, with the individual within 30 days of admission
	• Review and update the Individualized Treatment, Rehabilitation, and Recovery Plan every 90 days or more often as clinically indicated. Review must be completed with the individual under the direction of the program physician, PA, or APRN and must include family, guardians, and other supports authorized by the individual
	• Providers must establish a plan of care with a clinically appropriate maintenance period that is based on assessments of withdrawal symptoms using standardized scales
	
	Clinical Services
	
	• Dispensing and administration of opioid agonist medications: A physician, PA or APRN must prescribe and document, in writing, the initial treatment dose and schedule to be followed for each individual. This information is to be communicated to the licensed medical staff supervising the dispensing of all opioid replacement treatment
	• Psychotherapy services: Include individual, group and family psychotherapy to address the symptoms of addiction and related impaired functioning
	• Management for outpatient sustained recovery including methadone and buprenorphine
	• Maintenance medications for OUD must be based on the standards of care outlined in ASAM criteria, current edition
	
	## Support Services
	
	• Provide consultation, referral, or both for medical, psychological, and psychopharmacology needs
	• Assist the individual with accessing community supports and resources. The program must provide the following assistance as appropriate:
	  • Coordinate with community resources on behalf of the individual
	  • Assist with healthcare navigation

	• Coordinate with and facilitate access to external providers for individuals who require concurrent treatment
	• Assist individuals with application for and access to benefits and social support services
	• Assist individuals with reintegration into the community by identifying and connecting individuals with off-site vocational and educational resources
	
	Discharge Planning
	• Discharge planning is an ongoing process that occurs through the duration of service. A documented discharge plan must be completed as part of the Individualized Treatment, Rehabilitation, and Recovery Plan
	• A transition plan must be completed prior to discharge. A copy of the transition plan must be given to the individual and to providers at the individual's next level of care, as applicable
	• The program must assist individuals with transition and discharge planning. The program must provide the following assistance as appropriate:
	  • Assist individuals with identifying and accessing housing resources
	  • Coordinate with community resources on behalf of individuals to facilitate successful reintegration into daily activity such as work, school, or family living as appropriate
	  • Provide referrals and coordinate transition to a lower or higher level of care as clinically indicated

LENGTH OF SERVICE	Length of service is individualized and based on clinical criteria for admission and continuing stay. The anticipated duration of the service must be documented in the treatment, recovery, and rehabilitation plan
STAFFING	**Medical Director** Must be a physician with at least 1 year of experience in addiction medicine **Licensed Clinicians: as needed to meet staffing ratio** **Medication Dispensing staff:** Licensed clinicians who administer opioid agonist medication must be one of the following: • Pharmacist • Physician • APRN • RN

	• LPN under the supervision of the OTP Physician or APRN
STAFFING RATIO	Staffing must follow CMS requirements for Opioid Treatment Programs. Physician or APRN with controlled substance prescribing authority, including buprenorphine, must be available in person or via telehealth 24 hours a day, 7 days a week
HOURS OF OPERATION	To ensure access for all individuals, providers should be able to provide services during evening and weekend hours in addition to typical business hours. Weekend and evening hours may be by appointment as appropriate for established clients if the provider is not typically open outside of business hours.
CONTINUED STAY REQUIREMENTS	All of the following criteria must be met for continuing treatment at this level of care: • The acuity of the individual's symptoms continues to necessitate treatment at the current level of care based on admission criteria and ASAM guidelines • The individual does not require a more intensive level of services and no less intensive level of care is appropriate • The individual's treatment plan is up to date, with targets that are appropriate and related to improvement in the individual's symptoms and achievement of their goals. • The individual is making progress towards rehabilitation goals and they are showing progress towards symptom reduction as demonstrated by review of ASAM criteria, objective behavioral measurement of functional improvement, or standardized report from the member or guardian of symptom and/or functional improvement. • If progress has not been made or symptoms are increased, the treatment plan has been modified to focus on any new symptoms or to address barriers to progress. • There is evidence that the treatment team is working towards a transition plan to meet the individual's treatment needs once this level of care is no longer appropriate.
DESIRED INDIVIDUAL OUTCOME	• The individual's use of opioids is eliminated • The individual achieves remission of target symptoms and symptoms associated with opioid use disorder are mitigated. A relapse prevention and discharge plan has been created by the individual

	and appropriate licensed staff to address issues that may arise in the future

Parent Child Interaction Therapy

Parent Child Interaction Therapy (PCIT) may be provided to children from two years through twelve years of age. The emphasis of PCIT must be to improve the quality and nature of the parent-child relationship. It must be used to treat clinically significant disruptive behaviors due to the child's mental health disorder. Participation of the parent or primary caregiver in each session is a necessary component of PCIT.

SERVICE TYPE	Mental health
ALLOWABLE SETTINGS	• Community • Home • Office or Clinic
BILLING INFORMATION	Fee schedule code for this service is: • 90847 U7 – Parent Child Interaction Therapy (PCIT) Provider types which are allowed to bill for these services are outlined in the Mental Health and Substance Use Fee Schedule. **Telehealth** For current telehealth allowances for this service, please refer to the Medicaid Mental Health and Substance Use fee schedule
ADMISSION CRITERIA	• Age: 2 to 12 years of age ○ Individuals outside of this age range who are aged 20 or younger may be approved for services if clinical justification is submitted for prior authorization and approved • The individual demonstrates symptomatology consistent with a diagnosis as outlined in the current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association, which requires and can reasonably be expected to respond to therapeutic intervention • There are significant symptoms, caused by the behavioral health disorder diagnosis, that negatively impact a child's ability to function in at least one life area • Of all reasonable options available to the individual, this service is the best treatment option with expectation of improvement in the individual's behavioral functioning • PCIT is identified in the treatment plan as a treatment intervention for the individual
SERVICE REQUIREMENTS	**Assessments:** • Prior to PCIT services, a medical evaluation must be performed by a physician or APRN to rule out any medical conditions which may cause or contribute to the child's behavior

	• If an IDI was completed within 12 months prior to admission, and is determined to be clinically relevant, it may serve as the admission IDI. If there has been a gap in treatment of six months or more, or if there is new information available, an IDI addendum must be completed and may serve as the admission IDI
	• If an Initial Diagnostic Interview (IDI) has not been completed within the 12 months prior to admission, a new IDI or IDI addendum must be completed within 24 hours of the beginning of treatment. The IDI must meet the requirements as noted in the Initial Diagnostic Interview definition in this manual
	• A family assessment must be performed at the onset of PCIT. The family assessment must meet the requirements as noted in the Family Assessment definition in this manual
	
	Treatment Planning
	• An initial treatment plan must be developed within 24 hours of admission to guide the first 30 days of treatment
	• Under clinical supervision, develop an Individualized Treatment, Rehabilitation, and Recovery Plan, including discharge plan, with the individual within 30 days of admission
	• Review and update the Individualized Treatment, Rehabilitation, and Recovery Plan every 90 days or more often as clinically indicated. Review must be completed with the individual under the direction of a licensed clinician and must include family, guardians, other supports as authorized by the individual
	
	Clinical Services
	• Services must follow PCIT clinical protocols and best practices and must be tailored to each individual's level of clinical severity and designed to help the individual achieve changes in their symptoms
	• Provide training to the individual and their family, guardian, or caregivers in socially acceptable behaviors via modeling, prompting, roleplaying, and reinforcement of appropriate behaviors to promote consistency for the individual
	• Provide coaching to the family, guardian, or primary caregiver to learn and apply skills:
	  • To help children feel calm and secure in their relationships with their parent or primary caregiver.
	  • To help the parent and primary caregiver remain calm, confident and consistent in the parent and primary caregiver approach to the child accepting limits, complying with directions, respecting house rules, and demonstrating appropriate behavior in public
	• Services must involve the child and their family, guardian, or caregivers for the purpose of changing behavior, focusing on the level of family

	functioning as a whole and addressing issues related to the entire family system • All members of the family residing in the same household as the individual must participate in treatment as clinically appropriate • The goals, frequency, and duration of treatment will vary according to individual needs and response to treatment • During the therapy process, collaborative, person-focused progress tracking should be supported by periodic collection of objective behavioral indicators of functional status and/or standardized reports of symptom burden and functional status from the individual or their guardian. Reviewing these measures and their patterns over time directly with the individual or guardian helps ensure care remains aligned with their goals, supports shared decision-making, and promotes meaningful progress toward improved well-being **Support Services** • Provide access to Medication Assisted Treatment (MAT) as medically appropriate • Provide consultation, referral, or both for medical, psychological, and psychopharmacology needs • Assessments, treatment, and referral must address co-occurring needs • It is the provider's responsibility to coordinate with other treating professionals **Discharge Planning** • Discharge planning is an ongoing process that occurs through the duration of service. A documented discharge plan must be completed as part of the Individualized Treatment, Rehabilitation, and Recovery Plan • A transition plan must be completed prior to discharge. A copy of the transition plan must be given to the individual and to providers at the individual's next level of care, as applicable
LENGTH OF SERVICE	Length of service is individualized and based on clinical criteria for admission and continuing stay. The anticipated duration of the service must be documented in the Individualized Treatment, Rehabilitation, and Recovery Plan
STAFFING REQUIREMENTS	Licensed Clinicians: sufficient to meet staffing ratio All practitioners providing PCIT are required to be certified or actively working towards certification as a PCIT therapist. Practitioners must submit verification of their certification or training completed towards certification as a PCIT provider prior to providing PCIT services
STAFFING RATIO	1 Therapist: 1 Family

CONTINUING STAY GUIDELINES	All of the following criteria must be met for continuing treatment at this level of care: • The acuity of the individual's symptoms continues to necessitate treatment at the current level of care based on admission criteria • The individual does not require a more intensive level of services and no less intensive level of care is appropriate • The individual's treatment plan is up to date, with targets that are appropriate and related to improvement in the individual's symptoms and achievement of their goals. • The individual is making progress towards rehabilitation goals and they are showing progress towards symptom reduction as demonstrated by objective behavioral measurement of functional improvement or standardized report from the member or guardian of symptom and/or functional improvement. • If progress has not been made or symptoms are increased, the treatment plan has been modified to focus on any new symptoms or to address barriers to progress. • There is evidence that the treatment team is working towards a transition plan to meet the individual's treatment needs once this level of care is no longer appropriate. • The individual and their family, guardians, or caregivers are actively participating in treatment as clinically appropriate, or there are active, persistent efforts being made to engage them in treatment
DESIRED INDIVIDUAL OUTCOME	• The individual has substantially met the Individualized Treatment, Rehabilitation, and Recovery Plan goals and objectives • The precipitating condition and symptoms are stabilized such that there is sustained improvement in health and psychosocial functioning • The individual's symptoms can be managed without the professional external supports and intervention at this level of care • The individual's family, guardians, or caregivers have formal and informal support systems secured to maintain the individual's stability in the community

Psychiatric Nursing

Information on psychiatric home health nursing can be found in the Home Health section of this manual.

Published: November 20, 2026
Effective date: February 1, 2027

Psychotherapy - Individual, Family, and Group

Outpatient psychotherapy for mental health, substance use, or co-occurring disorders may be provided to adults or youth. Psychotherapy consists of professionally directed evaluation, treatment and recovery services for individuals experiencing a mental health, substance use, or co-occurring disorder that causes moderate or acute disruptions in the individual's life.

Substance Use Disorder Psychotherapy

Psychotherapy for individuals, families and groups with substance use disorders must be in alignment with American Society of Addiction Medicine (ASAM), 4th edition, level 1.5 guidelines

Individual Psychotherapy

Individual therapy is a one-on-one process between a licensed clinician and the individual, using evidence-based techniques to promote insight, reduce maladaptive behaviors, build adaptive, value-driven actions, manage distress, and improve interpersonal and social functioning. These processes can focus on behavioral health, substance use or both.

Family Psychotherapy

Family therapy is a structured therapeutic process involving a licensed clinician, the individual, and their defined family members. The clinician works with the family system to leverage strengths, improve communication, resolve conflicts, and support healthy functioning. This approach addresses patterns and dynamics that influence recovery and overall well-being, and is applicable to substance use and/or behavioral health treatment.

A Family Assessment must be completed at the initiation of family psychotherapy services. The family assessment must meet the requirements outlined in this document.

Group Psychotherapy

Group therapy is a structured therapeutic process involving a licensed clinician and multiple individuals who share similar treatment goals. The clinician facilitates interaction and peer support to promote insight, reduce maladaptive behaviors, and build adaptive coping strategies. This approach emphasizes shared experiences, skill development, and social functioning, and is applicable to substance use or behavioral health treatment.

SERVICE CATEGORY	• Mental health, substance use disorder, or both
ALLOWABLE SETTINGS	• Community • Home • Office or Clinic
BILLING INFORMATION	Fee schedule codes for this service are: Individual psychotherapy: • 90832 - Individual Psychotherapy (30 minutes) • 90834 - Individual Psychotherapy (45 minutes) • 90837 - Individual Psychotherapy (60 minutes) • 90832 HF - Individual Psychotherapy – substance use disorder (30 minutes) • 90834 HF - Individual Psychotherapy – substance use disorder (45 minutes) • 90837 HF - Individual Psychotherapy – substance use disorder (60 minutes) Family psychotherapy: • 90846 - Family Psychotherapy, Individual Not Present • 90847 - Family Psychotherapy with Individual Present • 90846 HF - Family Psychotherapy – substance use disorder, Individual Not Present • 90847 HF - Family Psychotherapy – substance use disorder with Individual Present Group psychotherapy: • 90853 - Group Psychotherapy • 90853 HF - Group Psychotherapy – substance use disorder When psychotherapy is listed as a service requirement in another service definition, it is included in the reimbursement for that service and may not be billed separately unless otherwise specified. **Telehealth** For current telehealth allowances for this service, please refer to the Medicaid Mental Health and Substance Use fee schedule
ADMISSION CRITERIA	Age: Any **For mental health treatment**: • The individual must demonstrate symptomatology consistent with a diagnosis as outlined in the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric

	Association, which requires and can reasonably be expected to respond to therapeutic intervention **For substance use disorder treatment:** • The individual meets the diagnostic criteria for a substance use disorder as defined in the current edition of the Diagnostic and Statistical Manual (DSM), current edition • The individual meets applicable dimensional criteria for admission to this service according to the American Society of Addiction Medicine (ASAM), 4th edition criteria • It is expected that the individual will be able to benefit from this treatment • There are significant symptoms as a result of the diagnosis that interfere with the individual's ability to function in at least one life area • This level of care is the least restrictive setting that will produce the desired results in accordance with the needs of the individual
SERVICE REQUIREMENTS	**Assessments** • If an IDI was completed within 12 months prior to admission, and is determined to be clinically relevant, it may serve as the admission IDI. If there has been a gap in treatment of six months or more, or if there is new information available, an IDI addendum must be completed and may serve as the admission IDI. • If an Initial Diagnostic Interview (IDI) has not been completed within the 12 months prior to admission, a new IDI or IDI addendum must be completed within 3 sessions from the beginning of treatment. The IDI must meet the requirements as noted in the Initial Diagnostic Interview definition in this manual *If the individual is being treated for a substance use disorder only, a substance use disorder (SUD) assessment may be completed as a substitute for an IDI:* • If an SUD assessment was completed within 12 months prior to admission to the service, and is determined to be clinically relevant, it can serve as the service admission assessment. If there has been a gap in treatment of six months or more, or if there is new information available, an SUD addendum must be completed and may serve as the admission SUD assessment • If an SUD assessment has not been completed within the 12 months prior to admission, a new SUD assessment or addendum must be completed within three sessions from the beginning of treatment and must establish the need for this service. The SUD assessment must meet the requirements outlined in the SUD Assessment definition in this manual

	Treatment Planning • An initial treatment plan must be developed within 3 sessions of admission to guide the first 30 days of treatment • Under clinical supervision, develop an Individualized Treatment, Rehabilitation, and Recovery Plan, including discharge plan, with the individual within 30 days of admission • Review and update the Individualized Treatment, Rehabilitation, and Recovery Plan every 90 days or more often as clinically indicated. Review must be completed with the individual under the direction of a licensed clinician and must include family, guardians, other supports as authorized by the individual **Clinical Services** • Services must follow clinical protocols and best practices, and must be tailored to each individual's level of clinical severity and designed to help the individual achieve improvements in their mental health symptoms, or alcohol or substance use behaviors • Interventions must target the individual's behavioral, cognitive, or daily living issues that may undermine treatment goals or impair the individual's ability to function in at least one life area • The goals, frequency, and duration of treatment will vary according to individual needs and response to treatment • Assessments, treatment, and referral must address co-occurring needs, when appropriate • Co-occurring mental health or substance use disorder conditions that are stable must be monitored • During the therapy process, collaborative, person-focused progress tracking should be supported by periodic collection of objective behavioral indicators of functional status and/or standardized reports of symptom burden and functional status from the individual or their guardian. Reviewing these measures and their patterns over time directly with the individual helps ensure care remains aligned with their goals, supports shared decision-making, and promotes meaningful progress toward improved well-being **Support Services** • Provide access to Medication Assisted Treatment (MAT) as medically appropriate • Provide access to a Physician or APRN for a physical exam as clinically indicated • Provide consultation, referral, or both for medical, psychological, and psychopharmacology needs • Assessments, treatment, and referral must address co-occurring needs, when appropriate • It is the provider's responsibility to coordinate with other treating professionals

	Discharge Planning • Discharge planning is an ongoing process that occurs through the duration of service. A documented discharge plan must be completed as part of the Individualized Treatment, Rehabilitation, and Recovery Plan • A transition plan must be completed prior to discharge. A copy of the transition plan must be given to the individual and to providers at the individual's next level of care, as applicable
LENGTH OF SERVICE	Length of service is individualized and based on clinical criteria for admission and continuing stay. The anticipated duration of the service must be documented in the Individualized Treatment, Rehabilitation, and Recovery Plan. Up to 30 hours of combined individual, family, and group psychotherapy may be provided without prior authorization per individual, per state fiscal year. The 30 visit limit does not apply to psychotherapy as part of residential or inpatient services, crisis psychotherapy, psychotherapy as part of IOP, Day Treatment, or Day Rehabilitation services, or crisis psychotherapy. Additional psychotherapy hours may be requested in certain clinical circumstances for which clinical justification must be submitted for prior authorization and be approved.
STAFFING REQUIREMENTS	Psychotherapy services must be provided by licensed clinicians as defined in this document, operating within their professional competencies.
STAFFING RATIO	Individual psychotherapy: 1 Licensed clinician: 1 Individual Family psychotherapy: 1 Licensed clinician: 1 Family Group psychotherapy: 1 Licensed clinician for up to 12 individuals
HOURS OF OPERATION	To ensure access for all individuals, providers should be able to provide services during evening and weekend hours in addition to typical business hours. Weekend and evening hours may be by appointment as appropriate for established clients if the provider is not typically open outside of business hours.
CONTINUED STAY REQUIREMENTS	All of the following criteria must be met for continuing treatment at this level of care: • The acuity of the individual's symptoms continues to necessitate treatment at the current level of care based on admission criteria, and ASAM guidelines if the individual is receiving treatment for substance use disorders, • The individual does not require a more intensive level of services and no less intensive level of care is appropriate

	• The individual's treatment plan is up to date, with targets that are appropriate and related to improvement in the individual's symptoms and achievement of their goals. • The individual is making progress towards rehabilitation goals and they are showing progress towards symptom reduction as demonstrated by objective behavioral measurement of functional improvement, standardized report from the member or guardian of symptom or functional improvement, and review of ASAM criteria for this level of care if the individual is receiving treatment for a substance use disorder • If progress has not been made or symptoms are increased, the treatment plan has been modified to focus on any new symptoms or to address barriers to progress. • There is evidence that the treatment team is working towards a transition plan to meet the individual's treatment needs once this level of care is no longer appropriate.
DESIRED INDIVIDUAL OUTCOME	• The individual has substantially met the treatment, recovery, and rehabilitation plan goals and objectives • The precipitating condition and relapse potential is stabilized such that there is sustained improvement in health and psychosocial functioning • The individual's condition can be managed without the professional external supports and intervention at this level of care • The individual has alternative support systems secured to help maintain active recovery and stability in the community • The individual is connected to the next appropriate level of care necessary to treat the condition

Tobacco Cessation

Tobacco Cessation services are provided as counseling sessions by a licensed Physician, APRN, PA, or licensed pharmacist

SERVICE CATEGORY	Substance use disorder
ALLOWABLE SETTINGS	• Community • Home • Office or Clinic
ADMISSION REQUIREMENTS	• Age: 18 years of age or older • The individual is a current user of tobacco products and desires to be tobacco free
SERVICE EXPECTATIONS	**Assessments** • A licensed Physician, APRN, or PA must evaluate the individual for tobacco use and prescribes tobacco cessation counseling as appropriate **Clinical Services** • Prescription of tobacco cessation pharmaceutical products as medically appropriate • Counseling by a tobacco cessation counselor. The tobacco counseling visits may be intermediate or intensive in nature. • Access to the Nebraska Tobacco Free Quit line. Referral to the quit line may be made by a health care practitioner, or by self-referral
LENGTH OF SERVICE	• Up to two prescriptions for tobacco cessation counseling may be covered in a 12-month period • One tobacco cessation counseling prescription includes up to 4 tobacco counseling visits • Access to the Nebraska tobacco free quit line is unlimited
STAFFING	**Licensed Clinicians** Must be one of the following: • Physician • APRN • PA • Licensed pharmacist with a tobacco counseling certification

	All licensed clinicians providing this service must have training or certification in tobacco counseling
STAFFING RATIO	1 licensed clinician: 1 individual
HOURS OF OPERATION	To ensure access for all individuals, providers should be able to provide services during evening and weekend hours in addition to typical business hours. Weekend and evening hours may be by appointment as appropriate for established clients if the provider is not typically open outside of business hours.
CONTINUED STAY REQUIREMENTS	N/A
DESIRED INDIVIDUAL OUTCOME	• The individual's use of tobacco is eliminated • The individual achieves remission of target symptoms and symptoms associated with tobacco use are mitigated. A relapse prevention and discharge plan has been created by the individual and appropriate licensed staff to address issues that may arise in the future

Partial Outpatient Services

Day Rehabilitation

Day rehabilitation services are designed to provide individualized treatment and recovery, inclusive of psychiatric rehabilitation and support for individuals with a severe and persistent mental illness and any co-occurring disorders who need a program with variable hours. The intent of the service is to support the individual in the recovery process so that the individual can be successful in a community living setting of their choice.

SERVICE CATEGORY	Mental health
SETTING	May be provided in the following settings: • Facility • Community
BILLING INFORMATION	Fee schedule codes for this service are: • H2017 - Day Rehabilitation Services - Partial Day - Minimum 12 Units (per 15 minutes) -Mental Health • H2018 - Day Rehabilitation Services - Full Day (per diem) Mental Health **Telehealth** This service must be provided in person. Peer support services, if provided by the program, are included in direct care staff time and may not be separately reimbursed.
ADMISSION REQUIREMENTS	• Age: 21 years of age and older – for youth eligibility, refer to EPSDT requirements as outlined in the definition section of this manual. • The individual must demonstrate symptomatology consistent with a diagnosis as outlined in the current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association, which requires and can reasonably be expected to respond to therapeutic intervention • The individual meets criteria for a severe mental illness as evidenced by functional limitations related to the diagnosis that seriously interfere with the individual's ability to function independently in an appropriate manner in two of three functional areas: ○ Instrumental activities of daily living: inability to be employed or an ability to be employed only with extensive supports; deterioration or decompensation resulting in inability to establish or pursue educational goals within normal time

	frame or without extensive supports; or inability to consistently and independently carry out home management tasks ○ Social functioning: repeated inappropriate or inadequate social behavior or ability to behave appropriately only with extensive supports; or consistent participation in adult activities only with extensive supports or when involvement is mostly limited to special activities established for persons with mental illness; or history of dangerousness to self or others ○ Activities of daily living: inability to consistently perform the range of practical daily living tasks required for basic adult functioning as evidenced by functional limitations in at least three of the following areas: ▪ Grooming, hygiene, washing clothes, meeting nutritional needs ▪ Care of personal business affairs ▪ Transportation and care of residence ▪ Procurement of medical, legal, and housing services ▪ Recognition and avoidance of common dangers or hazards to self and possessions • The individual is at risk of institutionalization or being unable to function in the community without this level of intervention, or less intensive treatment has been attempted but has not improved or stabilized the individual's symptoms, or the individual is transitioning to the community from a higher level of care • The individual's diagnosis is consistent with a long standing serious and persistent mental illness with symptoms of sufficient severity and duration that it is expected to cause significant, ongoing, disabling functional impairments. These impairments are beyond the scope of the person's informal support system to remediate and require professional assistance to guide the individual to recovery • This level of care is the least restrictive setting that will produce the desired results in accordance with the needs of the individual
SERVICE EXPECTATIONS	## Assessments • If an IDI was completed within 12 months prior to admission, and is determined to be clinically relevant, it may serve as the admission IDI. If there has been a gap in treatment of six months or more, or if there is new information available, an IDI addendum must be completed and may serve as the admission IDI. • If an Initial Diagnostic Interview (IDI) has not been completed within the 12 months prior to admission, a new IDI or IDI addendum must be completed within 24 hours of the beginning of treatment. The IDI must meet the requirements as noted in the Initial Diagnostic Interview definition in this manual

	• Consistent with the Admission Requirements, a baseline of functional status should be established by standardized assessment of Instrumental Activities of Daily Living, Social function and basic Activities of Daily Living
	• Referral to a Physician or APRN for a physical exam if the individual has not had a physical exam within the past 12 months, to be completed within 30 days of admission or sooner if indicated. The physical exam must include assessment for addiction medication needs as indicated
	
	Treatment Planning
	• An initial treatment plan must be developed within 1 business day of admission to guide the first 30 days of treatment
	• Under clinical supervision, develop an Individualized Treatment, Rehabilitation, and Recovery Plan, including discharge plan, with the individual within 30 days of admission
	• Review and update the Individualized Treatment, Rehabilitation, and Recovery Plan every 90 days or more often as clinically indicated. Review must be completed with the individual under the direction of a licensed clinician and must include family, guardians, other supports as authorized by the individual
	
	Clinical Services
	• Provide daily clinical services for a minimum of 15 hours per week. Services must be provided as either half days (three hours a day, five days a week), or full days (six hours a day, five days a week). The amount, frequency, and intensity of services must be appropriate to individual needs and level of function as determined by clinical assessment. Interventions must include:
	  ○ Psychoeducational groups
	  ○ Medication education (optional)
	• Psychoeducational groups must be provided under the direction of licensed clinicians, and may be provided by licensed clinicians or direct care staff
	• Medication education, if provided, must be provided by a physician, APRN, pharmacist, PA, RN, or LPN under RN supervision All services and individual compliance must be documented with daily progress notes
	• The clinical director must review individual clinical needs every 30 days. The review may be accomplished by the clinical director consulting with program clinical and direct care staff caring for the individual to identify clinical recommendations.
	Support Services
	• Provide access to Medication Assisted Treatment (MAT) as medically appropriate
	• Provide consultation, referral, or both for medical, psychological, and psychopharmacology needs

	• Assist the individual with accessing community supports and resources. The program must provide the following assistance as appropriate:
	  ○ Coordinate with community resources on behalf of the individual
	  ○ Assist with healthcare navigation
	  ○ Coordinate with and facilitate access to external providers for individuals who require concurrent treatment
	  ○ Assist individuals with application for and access to benefits and social support services
	  ○ Assist individuals with reintegration into the community by identifying and connecting individuals with off-site vocational and educational resources
	• Peer support services may be provided but are not required
	
	Discharge Planning
	• Discharge planning is an ongoing process that occurs through the duration of service. A documented discharge plan must be completed as part of the Individualized Treatment, Rehabilitation, and Recovery Plan
	• A transition plan must be completed prior to discharge. A copy of the transition plan must be given to the individual and to providers at the individual's next level of care, as applicable
	• The program must assist individuals with transition and discharge planning. The program must:
	  ○ Assist individuals with identifying and accessing housing resources if being discharged to independent living
	  ○ Coordinate with community resources on behalf of individuals to facilitate successful reintegration into daily activity such as work, school, or family living as appropriate
	  ○ Provide referrals and coordinate transition to a lower or higher level of care as clinically indicated

LENGTH OF SERVICE	Length of service is individualized and based on clinical criteria for admission and continuing stay. The anticipated duration of the service must be documented in the treatment, recovery, and rehabilitation plan
STAFFING	**Clinical Director:** MH programs: five years of experience in mental health treatment preferred Must be one of the following: • Psychiatrist • Physician • Psychologist • Advanced practice registered nurse (APRN) • Physician Assistant (PA) • Licensed independent mental health practitioner (LIMHP)

	• Licensed mental health practitioner (LMHP) **Licensed Clinicians:** sufficient to meet staffing ratio **Direct care staff:** sufficient to meet staffing ratio **Optional staff may include:** Certified Peer Support Providers Peer support services, if provided by the program, are included in program reimbursement and may not be separately reimbursed
STAFFING RATIO	During all operating hours: 1 direct care staff or licensed clinician: 6 individuals Psychotherapeutic groups: 1 direct care staff or licensed clinician: 3-12 individuals
HOURS OF OPERATION	To ensure access for all individuals, providers must be able to provide services for a minimum of five days a week, up to seven days a week. Program availability should include days, evenings and weekends where possible.
CONTINUED STAY REQUIREMENTS	All of the following criteria must be met for continuing treatment at this level of care: • The acuity of the individual's symptoms continues to necessitate treatment at the current level of care based on admission criteria • The individual does not require a more intensive level of services and no less intensive level of care is appropriate • The individual's treatment plan is up to date, with targets that are appropriate and related to improvement in the individual's symptoms and achievement of their goals. • The individual is making progress towards rehabilitation goals and they are showing progress towards symptom reduction as demonstrated by objective behavioral measurement of functional improvement or standardized report from the member or guardian of symptom and/or functional improvement. Functional improvement should evaluate function in Instrumental Activities of Daily Living, Social function and basic Activities of Daily Living • If progress has not been made or symptoms are increased, the treatment plan has been modified to focus on any new symptoms or to address barriers to progress.

	• There is evidence that the treatment team is working towards a transition plan to meet the individual's treatment needs once this level of care is no longer appropriate.
DESIRED INDIVIDUAL OUTCOME	• The individual has substantially met the treatment, recovery, and rehabilitation plan goals and objectives • The precipitating condition and relapse potential is stabilized such that there is sustained improvement in health and psychosocial functioning • The individual's condition can be managed without the professional external supports and intervention at this level of care • The individual has alternative support systems secured to help maintain active recovery and stability in the community • The individual is connected to the next appropriate level of care necessary to treat the condition

Day Treatment

Day Treatment provides a community based, intensive, and coordinated set of individualized treatment services to individuals with mental health disorders who have difficulty functioning full-time in a school, work, or home environment and need the additional structured activities of this level of care. This service includes diagnostic, medical, psychiatric, psychosocial, and adjunctive treatment modalities in a highly structured setting.

Day Treatment for Substance Use Disorders

For programs providing substance use disorder or co-occurring mental health and substance use disorder treatment, services must align with current edition ASAM level 2.5 guidance

SERVICE CATEGORY	Mental health or substance use disorder, or both
SETTING	May be provided in the following settings: • Outpatient Hospital • Community
BILLING INFORMATION	Fee schedule codes for this service are: • **Individual psychotherapy** for Day Treatment may be billed using the U3 modifier in combination with these codes: 90832, 90833, 90834, 90836, 90837, 90838 • **Family psychotherapy** for Day Treatment may be billed using the U3 modifier in combination with these codes: 90846, 90847 For groups led by licensed clinicians: • H2027 Day Treatment group led by licensed clinician For direct care staff time: • H2012 Day Treatment, Full Day – Min 6 Units (per hour) • H2012 52 Day Treatment, Partial Day - Max 3 Units (per hour) • H2027 52 Day Treatment, Direct Care Staff (per 15 minutes) For substance use disorder day treatment, add the HF modifier **Telehealth** This service must be provided in person.

	Peer support services, if provided by the program, are included in direct care staff time and may not be separately reimbursed.
ADMISSION REQUIREMENTS	AGE: For youth programs: 20 years of age and younger For adult programs: 21 years of age and older FOR MENTAL HEALTH TREATMENT: • The individual must demonstrate symptomatology consistent with a mental health disorder diagnosis as outlined in the current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association, which requires and can reasonably be expected to respond to therapeutic intervention • History of psychiatric symptoms requiring medical stabilization • The individual has a history of instability in the community due to mental health symptoms FOR SUBSTANCE USE DISORDER TREATMENT: • The individual meets the diagnostic criteria for a substance use disorder as defined in the current edition of the Diagnostic and Statistical Manual (DSM), current edition, which requires and can reasonably be expected to respond to therapeutic intervention The individual meets applicable dimensional criteria for admission to this service according to the American Society of Addiction Medicine (ASAM), 4th edition criteria v FOR ALL PROGRAMS: • The individual has functional limitations related to the diagnosis that seriously interfere with the individual's ability to function independently in an appropriate manner in one of three functional areas: ○ Instrumental activities of daily living: inability to be employed or an ability to be employed only with extensive supports; deterioration or decompensation resulting in inability to establish or pursue educational goals within normal time frame or without extensive supports; or inability to consistently and independently carry out home management tasks ○ Social functioning: repeated inappropriate or inadequate social behavior or ability to behave appropriately only with extensive supports; or consistent participation in adult activities only with extensive supports or when involvement is mostly limited to special activities established for persons with mental illness; or history of dangerousness to self or others. ○ Activities of daily living: inability to consistently perform the range of practical daily living tasks required for basic adult

	functioning as evidenced by functional limitations in at least three of the following areas: ▪ Grooming, hygiene, washing clothes, meeting nutritional needs ▪ Care of personal business affairs ▪ Transportation and care of residence ▪ Procurement of medical, legal, and housing services ▪ Recognition and avoidance of common dangers or hazards to self and possessions • Less intensive treatment has been attempted but has not improved or stabilized the individual's symptoms • This level of care is the least restrictive setting that will produce the desired results in accordance with the needs of the individual
SERVICE EXPECTATIONS	**Assessments** • If an IDI was completed within 12 months prior to admission, and is determined to be clinically relevant, it may serve as the admission IDI. If there has been a gap in treatment of six months or more, or if there is new information available, an IDI addendum must be completed and may serve as the admission IDI • If an Initial Diagnostic Interview (IDI) has not been completed within the 12 months prior to admission, a new IDI or IDI addendum must be completed within 24 hours of the beginning of treatment. The IDI must meet the requirements as noted in the Initial Diagnostic Interview definition in this manual *If the individual is being treated for a substance use disorder only, a substance use disorder (SUD) assessment may be completed as a substitute for an IDI:* • If an SUD assessment was completed within 12 months prior to admission to the service, and is determined to be clinically relevant, it can serve as the service admission assessment. If there has been a gap in treatment of six months or more, or if there is new information available, an SUD addendum must be completed and may serve as the admission SUD assessment • If an SUD assessment has not been completed within the 12 months prior to admission, a new SUD assessment or addendum must be completed within 24 hours of the beginning of treatment and must establish the need for this service. The SUD assessment must meet the requirements outlined in the SUD Assessment definition in this manual • Consistent with the Admission Requirements, a baseline of functional status should be established by standardized assessment of

	Instrumental Activities of Daily Living, Social function and basic Activities of Daily Living • Referral to a Physician or APRN for a physical exam if the individual has not had a physical exam within the past 12 months, to be completed within 30 days of admission or sooner if indicated. The physical exam must include assessment for addiction medication needs as indicated **Treatment Planning** • An initial treatment plan must be developed within 1 business day of admission to guide the first 14 days of treatment • Under clinical supervision, develop an Individualized Treatment, Rehabilitation, and Recovery Plan, including discharge plan, with the individual within 14 days of admission • Review and update the Individualized Treatment, Rehabilitation, and Recovery Plan every 30 days or more often as clinically indicated. Review must be completed with the individual under the direction of a licensed clinician and must include family, guardians, other supports as authorized by the individual **Clinical Services** • Nursing services: A registered nurse must evaluate and provide for the care and treatment of the individual's medical nursing needs when medically indicated • Provide daily clinical services for a minimum of 9 hours per week. Services must be provided as either half days (three hours a day, five days a week), or full days (six hours a day, five days a week). The amount, frequency, and intensity of services must be appropriate to individual needs and level of function as determined by clinical assessment. Interventions must include: o One individual, family, or group psychotherapy session per day o Psychoeducational groups o Medication education (optional) • Psychoeducational groups must be provided under the direction of licensed clinicians, and may be provided by licensed clinicians or direct care staff • Medication education, if provided, must be provided by a physician, APRN, pharmacist, PA, RN, or LPN under RN supervision Supervising practitioners (physician or PhD) must be onsite a sufficient amount of time to provide for the clinical care of the individuals. The supervising practitioner's involvement must be reflected in the clinical record • The supervising practitioner must conduct an in-person session with each individual every 30 days, separate from the treatment plan review • Pharmaceutical services: If medications are dispensed by the

program, all medications must be stored in a designated locked storage space and administered by a physician, registered nurse, licensed practical nurse or a medication aid under the direction and monitoring of an RN, PA, APRN, or Physician
- All services and individual compliance must be documented with daily progress notes

Support Services

- Provide access to Medication Assisted Treatment (MAT) as medically appropriate
- Provide consultation, referral, or both for medical, psychological, and psychopharmacology needs
- Assist the individual with accessing community supports and resources. The program must provide the following assistance as appropriate:
    - Coordinate with community resources on behalf of the individual
    - Assist with healthcare navigation
    - Coordinate with and facilitate access to external providers for individuals who require concurrent treatment
    - Assist individuals with application for and access to benefits and social support services
    - Assist individuals with reintegration into the community by identifying and connecting individuals with off-site vocational and educational resources
- Peer support services may be provided but are not required

Discharge Planning

- Discharge planning is an ongoing process that occurs through the duration of service. A documented discharge plan must be completed as part of the Individualized Treatment, Rehabilitation, and Recovery Plan
- A transition plan must be completed prior to discharge. A copy of the transition plan must be given to the individual and to providers at the individual's next level of care, as applicable
- The program must assist individuals with transition and discharge planning. The program must:
    - Assist individuals with identifying and accessing housing resources if being discharged to independent living
    - Coordinate with community resources on behalf of individuals to facilitate successful reintegration into daily activity such as work, school, or family living as appropriate
    - Provide referrals and coordinate transition to a lower or higher level of care as clinically indicated

LENGTH OF SERVICE	Length of service is individualized and based on clinical criteria for admission and continuing stay. The anticipated duration of the service must be documented in the treatment, recovery, and rehabilitation plan
STAFFING REQUIREMENTS	**Clinical Director:** MH PROGRAMS: must have five years of experience in mental health treatment Must be one of the following: • Psychiatrist • Physician • Psychologist • Advanced practice registered nurse (APRN) • Physician Assistant (PA) • Licensed independent mental health practitioner (LIMHP) • Licensed mental health practitioner (LMHP) SUD PROGRAMS: must have five years of experience in substance use disorder treatment Any of the above, plus: Licensed Drug and Alcohol Counselor (LADC) **Licensed Clinicians:** sufficient to meet staffing ratio **Direct care staff:** sufficient to meet staffing ratio **Optional staff may include:** Certified Peer Support Providers Peer support services, if provided by the program, are included in program reimbursement and may not be separately reimbursed.
STAFFING RATIO	During all operating hours: 1 direct care staff or licensed clinician: 6 individuals Individual psychotherapy: 1 licensed clinician: 1 individual Group psychotherapy: 1 licensed clinician: 3 - 12 individuals Family psychotherapy: 1 licensed clinician: 1 family Psychotherapeutic groups: 1 direct care staff or licensed clinician: 3-12 individuals
HOURS OF OPERATION	To ensure access for all individuals, providers must be able to provide services for a minimum of five days a week, up to seven days a week. Program availability should include days, evenings and weekends where possible.

CONTINUED STAY REQUIREMENTS	All of the following criteria must be met for continuing treatment at this level of care: • The acuity of the individual's symptoms continues to necessitate treatment at the current level of care based on admission criteria, and ASAM guidelines if the individual is receiving treatment for substance use disorders, • The individual does not require a more intensive level of services and no less intensive level of care is appropriate • The individual's treatment plan is up to date, with targets that are appropriate and related to improvement in the individual's symptoms and achievement of their goals. • The individual is making progress towards rehabilitation goals and they are showing progress towards symptom reduction as demonstrated by objective behavioral measurement of functional improvement, standardized report from the member or guardian of symptom or functional improvement, and review of ASAM criteria for this level of care if the individual is receiving treatment for a substance use disorder. Functional improvement should evaluate function in Instrumental Activities of Daily Living, Social function and basic Activities of Daily Living • If progress has not been made or symptoms are increased, the treatment plan has been modified to focus on any new symptoms or to address barriers to progress. • There is evidence that the treatment team is working towards a transition plan to meet the individual's treatment needs once this level of care is no longer appropriate. All of the following criteria must be met for continuing treatment at this level of care: • The individual continues to meet Admission Requirements • The individual does not require a more intensive level of services and no less intensive level of care is appropriate • There is reasonable likelihood of substantial benefits as demonstrated by standardized measurements of functional improvement in Instrumental Activities of Daily Living, Social function and basic Activities of Daily Living • The individual is making progress towards rehabilitation goals • There is evidence of continued discharge planning and attempts to discharge
DESIRED INDIVIDUAL OUTCOME	• The individual has substantially met the treatment, recovery, and rehabilitation plan goals and objectives

	• The precipitating condition and relapse potential is stabilized such that there is sustained improvement in health and psychosocial functioning • The individual's condition can be managed without the professional external supports and intervention at this level of care • The individual has alternative support systems secured to help maintain active recovery and stability in the community • The individual is connected to the next appropriate level of care necessary to treat the condition

Intensive Outpatient

Intensive Outpatient services provide individual or group based, non-residential, intensive, structured interventions consisting primarily of counseling and psychoeducation about substance related and co-occurring mental health problems. Services are goal-oriented interactions with the individual or in group/family settings. This community-based service allows the individual to apply skills in natural environments and promotes a rapid and stable integration into the community. IOP provides time-limited, comprehensive, and coordinated multidisciplinary treatment. Services align with current edition ASAM 2.1 guidance

SERVICE CATEGORY	Mental health or substance use disorder, or both
SETTING	May be provided in the following settings: • Outpatient Hospital • Facility • Community
BILLING INFORMATION	Fee schedule codes for this service are: • **Individual psychotherapy** for IOP may be billed using the U5 modifier in combination with these codes: 90832, 90833, 90834, 90836, 90837, 90838 • **Family psychotherapy** for IOP may be billed using the U5 modifier in combination with these codes: 90846, 90847 **For IOP group treatment:** For groups led by licensed clinicians: • H2014 Intensive Outpatient group led by licensed clinician For IOP groups led by direct care staff: • H2014 52 Intensive Outpatient Direct Care Staff (per 15 minutes) **No more than 3 hours of H2014 (any modifier) may be billed per day.** **To indicate substance use disorder IOP services, add the HF modifier** **Telehealth** For current telehealth allowances for this service, please refer to the Medicaid Mental Health and Substance Use fee schedule Peer support services, if provided by the program, are included in direct care staff time and may not be separately reimbursed.

ADMISSION REQUIREMENTS	AGE: For youth programs: 20 years of age and younger For adult programs: 21 years of age and older FOR MENTAL HEALTH TREATMENT: • The individual must demonstrate symptomatology consistent with a mental health disorder diagnosis as outlined in the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association, which requires and can reasonably be expected to respond to therapeutic intervention FOR SUBSTANCE USE DISORDER TREATMENT: • The individual meets the diagnostic criteria for a substance use disorder as defined in the current edition of the Diagnostic and Statistical Manual (DSM), current edition, which requires and can reasonably be expected to respond to therapeutic intervention The individual meets applicable dimensional criteria for admission to this service according to the American Society of Addiction Medicine (ASAM), 4th edition criteria ADDITIONAL ADMISSION CRITERIA FOR PROGRAMS TREATING EATING DISORDERS OR INDIVIDUALS AT RISK OF SEXUAL HARM: • The individual must have a documented history of eating disorders or sexually harmful behaviors FOR ALL PROGRAMS: • It is expected that the individual will be able to benefit from this treatment • This level of care is the least restrictive setting that will produce the desired results in accordance with the needs of the individual • Less intensive treatment has been attempted but has not improved or stabilized the individual's symptoms • This level of care is the least restrictive setting that will produce the desired results in accordance with the needs of the individual
SERVICE EXPECTATIONS	**Assessments** • If an IDI was completed within 12 months prior to admission, and is determined to be clinically relevant, it may serve as the admission IDI. If there has been a gap in treatment of six months or more, or if there is new information available, an IDI addendum must be completed and may serve as the admission IDI • If an Initial Diagnostic Interview (IDI) has not been completed within the 12 months prior to admission, a new IDI or IDI addendum must be completed within 24 hours of the beginning of treatment. The IDI must meet the requirements as noted in the Initial Diagnostic Interview definition in this manual

	If the individual is being treated for a substance use disorder only, a substance use disorder (SUD) assessment may be completed as a substitute for an IDI:
	• If an SUD assessment was completed within 12 months prior to admission to the service, and is determined to be clinically relevant, it can serve as the service admission assessment. If there has been a gap in treatment of six months or more, or if there is new information available, an SUD addendum must be completed and may serve as the admission SUD assessment
	• If an SUD assessment has not been completed within the 12 months prior to admission, a new SUD assessment or addendum must be completed within 24 hours of the beginning of treatment and must establish the need for this service. The SUD assessment must meet the requirements outlined in the SUD Assessment definition in this manual
	• Referral to a Physician or APRN for a physical exam if the individual has not had a physical exam within the past 12 months, to be completed within 30 days of admission or sooner if indicated. The physical exam should include assessment for addiction medication needs as indicated
	
	Treatment Planning
	• An initial treatment plan must be developed within 1 business day of admission to guide the first 14 days of treatment
	• Under clinical supervision, develop an Individualized Treatment, Rehabilitation, and Recovery Plan, including discharge plan, with the individual within 14 days of admission
	• Review and update the Individualized Treatment, Rehabilitation, and Recovery Plan every 30 days or more often as clinically indicated. Review must be completed with the individual under the direction of a licensed clinician and must include family, guardians, other supports as authorized by the individual
	
	Clinical Services
	• Adult services must provide daily clinical services for 9 hours per week, maximum of 3 hours per day
	• Youth programs must provide daily clinical services for 6 hours per week, maximum of 3 hours per day
	• The amount, frequency, and intensity of services must be appropriate to individual needs and level of function as determined by clinical assessment.
	• Interventions must include:
	  ○ A maximum of one individual and family psychotherapy session per week may count towards the 9-hour total
	  ○ Psychoeducational groups
	  ○ Medication education

- Psychoeducational groups must be provided under the direction of licensed clinicians, and may be provided by licensed clinicians or direct care staff
- Medication education must be provided by a registered nurse

Support Services

- Provide access to Medication Assisted Treatment (MAT) as medically appropriate
- Provide consultation, referral, or both for medical, psychological, and psychopharmacology needs
- Assist the individual with accessing community supports and resources. The program must provide the following assistance as appropriate:
    - Coordinate with community resources on behalf of the individual
    - Assist with healthcare navigation
    - Coordinate with and facilitate access to external providers for individuals who require concurrent treatment
    - Assist individuals with application for and access to benefits and social support services
    - Assist individuals with reintegration into the community by identifying and connecting individuals with off-site vocational and educational resources
- Peer support services may be provided but are not required

Discharge Planning

- Discharge planning is an ongoing process that occurs through the duration of service. A documented discharge plan must be completed as part of the Individualized Treatment, Rehabilitation, and Recovery Plan
- A transition plan must be completed prior to discharge. A copy of the transition plan must be given to the individual and to providers at the individual's next level of care, as applicable
- The program must assist individuals with transition and discharge planning. The program must:
    - Assist individuals with identifying and accessing housing resources if being discharged to independent living
    - Coordinate with community resources on behalf of individuals to facilitate successful reintegration into daily activity such as work, school, or family living as appropriate
    - Provide referrals and coordinate transition to a lower or higher level of care as clinically indicated

LENGTH OF SERVICE	Length of service is individualized and based on clinical criteria for admission and continuing stay. The anticipated duration of the service must be documented in the treatment, recovery, and rehabilitation plan
STAFFING	**Clinical Director:** MH PROGRAMS: must have five years of experience in mental health treatment All programs: Must be one of the following: • Psychiatrist • Physician • Psychologist • Advanced practice registered nurse (APRN) • Physician Assistant (PA) • Licensed independent mental health practitioner (LIMHP) • Licensed mental health practitioner (LMHP) SUD PROGRAMS: must have five years of experience in substance use disorder treatment Any of the above, plus: Licensed Drug and Alcohol Counselor (LADC) **Licensed Clinicians:** sufficient to meet staffing ratio **Direct care staff:** sufficient to meet staffing ratio Licensed medical providers, licensed clinicians and direct care staff must be available on-call 24 hours a day
STAFFING RATIO	Individual psychotherapy: 1 licensed clinician: 1 individual Group psychotherapy: 1 licensed clinician: 3 - 12 individuals Family psychotherapy: 1 licensed clinician: 1 family Psychotherapeutic groups: 1 direct care staff or licensed clinician: 3-12 individuals For programs serving youth under age 21: a minimum of 1 direct care staff or licensed clinician: 6 individuals during all operating hours
HOURS OF OPERATION	To ensure access for all individuals, providers must be able to provide services for a minimum of five days a week, up to seven days a week. Program availability should include days, evenings and weekends where possible.
CONTINUED STAY REQUIREMENTS	All of the following criteria must be met for continuing treatment at this level of care:

	• The acuity of the individual's symptoms continues to necessitate treatment at the current level of care based on admission criteria, and ASAM guidelines if the individual is receiving treatment for substance use disorders, • The individual does not require a more intensive level of services and no less intensive level of care is appropriate • The individual's treatment plan is up to date, with targets that are appropriate and related to improvement in the individual's symptoms and achievement of their goals. • The individual is making progress towards rehabilitation goals and they are showing progress towards symptom reduction as demonstrated by objective behavioral measurement of functional improvement, standardized report from the member or guardian of symptom or functional improvement, and review of ASAM criteria for this level of care if the individual is receiving treatment for a substance use disorder • If progress has not been made or symptoms are increased, the treatment plan has been modified to focus on any new symptoms or to address barriers to progress. • There is evidence that the treatment team is working towards a transition plan to meet the individual's treatment needs once this level of care is no longer appropriate.
DESIRED INDIVIDUAL OUTCOME	• The individual has substantially met the treatment, recovery, and rehabilitation plan goals and objectives • The precipitating condition and relapse potential is stabilized such that there is sustained improvement in health and psychosocial functioning • The individual's condition can be managed without the professional external supports and intervention at this level of care • The individual has alternative support systems secured to help maintain active recovery and stability in the community • The individual is connected to the next appropriate level of care necessary to treat the condition

Residential Services – MH

Psychiatric Residential Rehabilitation

Psychiatric Residential Rehabilitation provides individualized treatment, psychiatric rehabilitation and support for individuals with a severe and persistent mental illness and co-occurring disorders needing structured recovery and rehabilitation activities within a residential setting. Psychiatric Residential Rehabilitation is provided by a treatment and recovery team in a 24-hour staffed residential facility. The intent of the service is to support the individual by improving symptom management and life skills so that they can be successful in a community living setting of their choice

SERVICE CATEGORY	Mental health
SETTING	• Facility
BILLING INFORMATION	Fee schedule code for this service is: • H0019 HE – Psychiatric Residential Rehabilitation Services ○ This code is per diem, not including daily room and board **Telehealth:** Services in residential and inpatient programs must be provided in person except as listed below. Elements of this service may be provided by telehealth as follows: **PSYCHOTHERAPY:** Individual, group, and family psychotherapy may be provided via audiovisual telehealth for no more than 10% of psychotherapy services provided for each individual.
ADMISSION REQUIREMENTS	• Age: 21 years of age or older – for youth eligibility, refer to EPSDT requirements as outlined in the definition section of this manual. All of the following must be present: **Serious Mental Illness (SMI)**: Individuals with serious mental illness are defined as individuals that meet the following criteria: • A Diagnostic and Statistical Manual of Mental Disorders (DSM) (current edition) diagnosis consistent with a long standing serious and persistent mental illness with symptoms of sufficient severity and duration that it is expected to cause significant, ongoing, disabling functional impairments. These impairments are beyond the scope of

	the person's informal support system to remediate and require professional assistance to guide the individual to recovery
	• Persistent mental illness as demonstrated by the presence of the disorder for the last 12 months or which is expected to last 12 months or longer and will result in a degree of limitation that seriously interferes with the individual's ability to function independently in an appropriate manner in two of three functional areas:
	  ○ Activities of Daily Living: Inability to consistently perform the range of practical daily living tasks for basic adult functioning in three of five of the following:
	  ▪ Grooming, hygiene, washing clothes, meeting nutritional needs
	  ▪ Care of personal business affairs
	  ▪ Transportation and care of residence
	  ▪ Procurement of medical, legal, and housing services, or
	  ▪ Recognition and avoidance of common dangers or hazards to self and possessions
	  ○ Vocational/Education:
	  ▪ Inability to be employed or an ability to be employed only with extensive supports
	  ▪ Deterioration or decompensation resulting in inability to establish or pursue educational goals within normal time frame or without extensive supports, or
	  ▪ Inability to consistently and independently carry out home management tasks
	  ○ Social skills:
	  ▪ Repeated inappropriate or inadequate social behavior or ability to behave appropriately only with extensive supports
	  ▪ Consistent participation in adult activities only with extensive supports or when involvement is mostly limited to special activities established for persons with mental illness, or
	  ▪ History of dangerousness to self/others
	• The individual is at significant risk of continuing in a pattern of either institutionalization or living in a severely dysfunctional manner if needed rehabilitation services are not provided, as evidenced by impaired function in one additional functional area listed above. Symptoms and functional deficits are related to the primary diagnosis.
	• Individual's functional deficits are of such intensity that a 24-hour psychiatric residential setting is required
	• Requires 24-hour awake staff to assist with psychiatric rehabilitation

SERVICE EXPECTATIONS	**Assessments**
	• If an IDI was completed within 12 months prior to admission, and is determined to be clinically relevant, it may serve as the admission IDI. If there has been a gap in treatment of six months or more, or if there is new information available, an IDI addendum must be completed and may serve as the admission IDI
	• If an Initial Diagnostic Interview (IDI) has not been completed within the 12 months prior to admission, a new IDI or IDI addendum must be completed within 24 hours of the beginning of treatment. The IDI must meet the requirements as noted in the Initial Diagnostic Interview definition in this manual
	• A History and Physical (H&P) does not meet the requirements of this definition and may not substitute for an IDI.
	• Consistent with the Admission Requirements, a baseline of functional status should be established by standardized assessment of Instrumental Activities of Daily Living, Social function and basic Activities of Daily Living
	• Perform or refer for physical examination if the individual has not had a physical exam within the past 12 months. If performed by the program, the exam must be completed by a physician or APRN within 14 days of admission or sooner if indicated. Referrals must be completed within 14 days.
	
	Treatment Planning
	• An initial Treatment, Rehabilitation, and Recovery Plan must be developed within 24 hours of admission to guide the first seven days of treatment
	• Under clinical supervision, the individualized Treatment, Rehabilitation, and Recovery Plan, including discharge plan and relapse prevention must be developed with the individual within seven days of admission.
	• Review and update the individualized Treatment, Rehabilitation, and Recovery Plan every 45 days or more often as clinically indicated. Review must be completed with the individual under the direction of a licensed clinician and must include family, guardians, other supports as authorized by the individual
	
	Clinical Services
	• Provide daily clinical services for a minimum of 25 hours per week. The amount, frequency, and intensity of services must be appropriate to individual needs and level of function. Interventions must include:
	  ◦ Psychoeducational groups
	  ◦ Medication education

	• Psychoeducational groups must be provided under the direction of licensed clinicians, and may be provided by licensed clinicians or direct care staff
	• Medication education must be provided by a physician, APRN, pharmacist, PA, RN, or LPN under RN supervision
	• Coordinate and offer a minimum of 20 hours a week of additional off-site rehabilitation, vocational, and educational activities
	• Treatment for co-occurring substance use disorder conditions must be provided as clinically indicated
	• All medications must be stored in a designated locked storage space and administered by a physician, registered nurse, licensed practical nurse or a medication aid under the direction and monitoring of an RN, PA, APRN, or Physician
	
	Support Services
	• Provide access to Medication Assisted Treatment (MAT) as medically appropriate
	• Arrange for psychiatric services as needed
	• Consultation, referral, or both for medical, psychological, and psychopharmacology needs
	• Assist the individual with accessing community supports and resources. The program must provide the following assistance as appropriate:
	  • Coordinate with community resources on behalf of the individual
	  • Assist with healthcare navigation
	  • Coordinate with and facilitate access to external providers for individuals who require concurrent treatment
	  • Assist individuals with application for and access to benefits and social support services
	  • Assist individuals with reintegration into the community by identifying and connecting individuals with off-site vocational and educational resources
	• Optional: Peer support services
	
	Discharge Planning
	• Discharge planning is an ongoing process that occurs through the duration of service. A documented discharge plan must be completed as part of the individualized Treatment, Rehabilitation, and Recovery Plan
	• A transition plan must be completed prior to discharge. A copy of the transition plan must be given to the individual and to providers at the individual's next level of care, as applicable

	• The program must assist individuals with transition and discharge planning. The program must provide the following assistance as appropriate:
	  • Assist individuals with identifying and accessing housing resources
	  • Coordinate with community resources on behalf of individuals to facilitate successful reintegration into daily activity such as work, school, or family living as appropriate
	  • Provide referrals and coordinate transition to a lower or higher level of care as clinically indicated
	• The program must contact the individual and the provider to which they were referred within 72 hours of discharge to ensure continuity of care. If the individual refuses referral or the program is unable to contact the individual this must be documented.

LENGTH OF SERVICE	Length of service is individualized and based on clinical criteria for admission and continuing stay. The anticipated duration of the service must be documented in the individualized Treatment, Rehabilitation, and Recovery Plan
STAFFING	**Clinical Director:** Must be one of the following: • Psychiatrist • Physician • Advanced practice registered nurse (APRN) • Licensed Physician Assistant (PA) • Licensed psychologist • Licensed independent mental health practitioner (LIMHP) • Licensed mental health practitioner (LMHP) **Direct Care staff:** Sufficient to meet staffing ratio **Medication Oversight staff** Clinical staff must be available on-site sufficient to provide training and oversight to medication administration staff. This position may be part-time or contracted**:** • Psychiatrist • Physician • Pharmacist • Advanced practice registered nurse (APRN) • Licensed Physician Assistant (PA) • Registered Nurse (RN)

	Optional staff may include: • Community support worker • Certified peer support provider Peer support, community support, and medication management services, if provided by the program, are included in reimbursement and may not be separately reimbursed
STAFFING RATIO	Direct care staff to individual during day hours 1:10 Awake staff to individuals during night hours 1:10 • Sufficient supervisory staff must be available (in person or on-call) to respond to urgent situations A licensed clinician must be available on-call 24 hours a day
HOURS OF OPERATION	24 hours a day, seven days a week
CONTINUED STAY REQUIREMENTS	All of the following criteria must be met for continuing treatment at this level of care: • The acuity of the individual's symptoms continues to necessitate treatment at the current level of care based on admission criteria • The individual does not require a more intensive level of services and no less intensive level of care is appropriate • The individual's treatment plan is up to date, with targets that are appropriate and related to improvement in the individual's symptoms and achievement of their goals. • The individual is making progress towards rehabilitation goals and they are showing progress towards symptom reduction as demonstrated by objective behavioral measurement of functional improvement or standardized report from the member or guardian of symptom and/or functional improvement. • If progress has not been made or symptoms are increased, the treatment plan has been modified to focus on any new symptoms or to address barriers to progress. • There is evidence that the treatment team is working towards a transition plan to meet the individual's treatment needs once this level of care is no longer appropriate.

DESIRED INDIVIDUAL OUTCOME	• The individual has substantially met the individualized Treatment, Rehabilitation, and Recovery Plan goals and objectives • The precipitating condition and relapse potential is stabilized such that the individual's condition can be managed without this level of professional interventions • Individual has formal and informal support systems secured to maintain stability in a lower level of care

Psychiatric Residential Treatment Facility

A Psychiatric Residential Treatment Facility (PRTF) is a facility that provides inpatient psychiatric services to individuals under the age of 21. An independent team that includes a psychiatrist evaluates and determines that ambulatory care resources available in the community do not meet the individual's treatment needs

SERVICE CATEGORY	Mental health
SETTING	• Inpatient hospital • Non-hospital inpatient setting
BILLING INFORMATION	Fee schedule codes for this service are: Hospital-based PRTFs: • H2013 - PRTF Hospital–Based (per diem) • H2013 UA - PRTF Hospital–Based: (Therapeutic Leave Day - TLD) Home • H2013 UB - PRTF Hospital–Based: (TLD) Psych Inpatient • H2013 UC - PRTF Hospital–Based: (TLD) Med/Surg Inpatient Community-based PRTFs: • T2048 - PRTF Community Based • T2048 UA - PRTF Community Based: (Therapeutic Leave Day) Home • T2048 UB - PRTF Community Based: (TLD) Psych inpatient • T2048 UC - PRTF Community Based: (TLD) Med/Surg Inpatient **Prior authorization**: In order for an admission to a PRTF to be reimbursed by Medicaid, clinical justification for admission and the Certificate of Need must be submitted for prior authorization and be approved. PRTF services that are ordered by the court are not covered unless medical necessity criteria are met. **Telehealth:** Services in residential and inpatient programs must be provided in person except as listed below. Elements of this service may be provided by telehealth as follows: **MEDICATION MANAGEMENT** If the program is not able to identify a psychiatrist or APRN with a specialty certification in psychiatry who can be present at the facility,

	medication management may be completed via audiovisual telehealth if all of the following are true: ▪ There is a documented formal agreement with a single identified psychiatrist or APRN with a specialty certification in psychiatry to provide medication management services for the program ▪ The individual being treated does not have acute psychiatric or medical symptoms that require in-person assessment ▪ A physician, APRN, or RN is physically present with the individual during the medication check to report any physical symptoms that may not be apparent via audiovisual telehealth ▪ There is a documented plan in place to provide in-person care in case of an emergency or an acute change in the individual's symptoms **PSYCHOTHERAPY:** Individual, group, and family psychotherapy may be provided via audiovisual telehealth for no more than 10% of psychotherapy services provided for each individual.

ADMISSION REQUIREMENTS	Age**:** 20 years of age or younger
	Certificate of Need:
	• Prior to admission, PRTF admission must be recommended by Certificate of Need that is developed by the individual's outpatient treatment team, in alignment with federal PRTF requirements. Without such a team, an independent team that is not associated with the admitting PRTF may complete the Certificate of Need. The team must determine that PRTF treatment is the most clinically appropriate service for the individual.
	• The Certificate of Need must certify all of the following:
	  • Treatment resources available in the community do not meet the needs of the individual
	  • Proper treatment of the individual's psychiatric condition requires services on an inpatient basis under the direction of a physician
	  • PRTF services can reasonably be expected to improve the individual's condition or prevent further regression so that the services will no longer be needed
	• The Certificate of Need must be signed by all members of the team
	
	Certificate of Need team:

	• The team must include:
	  • A board-certified psychiatrist, or
	  • Physician or APRN who has competence in diagnosis and treatment of mental illness, preferably in child psychiatry, and
	  • Psychologist
	• All members of the team must be involved in treating the individual or have knowledge of the individual's situation
	
	Special Circumstances:
	  • For an individual who applies for Medicaid while in the PRTF, the certification must be made by the team responsible for the Individualized Treatment, Recovery, and Rehabilitation plan, and cover any period before application for which claims are made
	  • Emergency admissions: For emergency admissions, the certification must be made by the team responsible for the Individualized Treatment, Recovery, and Rehabilitation plan within 14 days after admission
	
	Additional Admission Criteria:
	• Less restrictive approaches have been tried and were not successful or were determined to not be appropriate to meet the individual's needs.
	• The individual demonstrates severe and persistent symptoms and functional impairments with a diagnosis as outlined in the current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association that requires 24-hour residential or inpatient psychiatric treatment under the direction of a physician.
	• The individual's symptoms or severe functional impairments include at least one of the following:
	  • Suicidal or homicidal ideation
	  • Substance use disorder that meets American Society of Addiction Medicine (ASAM), 4th edition, level of care 3.7
	  • Persistent or medically significant self-injury behaviors
	  • A pattern of physical and verbal aggression
	  • Significant eating disorder symptoms
	  • Severe mood instability
	  • Psychotic symptoms
	  • Sexually harmful behaviors
	• This level of care is the least restrictive setting that will produce the desired results in accordance with the needs of the individual

SERVICE EXPECTATIONS	**Assessments**
	• If an IDI was completed within 12 months prior to admission, and is determined to be clinically relevant, it may serve as the admission IDI. If there has been a gap in treatment of six months or more, or if there is new information available, an IDI addendum must be completed and may serve as the admission IDI.
	• If an Initial Diagnostic Interview (IDI) has not been completed within the 12 months prior to admission, a new IDI or IDI addendum must be completed within 24 hours of the beginning of treatment. The IDI must meet the requirements as noted in the Initial Diagnostic Interview definition in this manual
	• A History and Physical (H&P) does not meet the requirements of this definition and may not substitute for an IDI.
	
	Treatment Planning
	• An initial treatment plan must be developed within 24 hours, to guide the first 14 days of treatment
	• Under clinical supervision, develop an Individualized Treatment, Rehabilitation, and Recovery Plan (treatment plan), including discharge plan and relapse prevention, with the individual within 14 days of admission
	• The team developing the treatment plan must include, at a minimum, one of the following:
	  • Psychiatrist
	  • Psychologist and Physician
	  • Physician with specialized training and experience in the diagnosis and treatment of mental health disorders and a psychologist
	• The team developing the treatment plan must also include one of the following:
	  • Psychologist
	  • A social worker (CSW or MSW) with specialized training or one year's experience in treating individuals with mental health disorders
	  • A licensed registered nurse with specialized training or one year's experience in treating individuals with mental health disorders
	  • A licensed occupational therapist with specialized training or one year of experience in treating individuals with mental health disorders
	• Review and update the Individualized Treatment, Rehabilitation, and Recovery Plan every 30 days or more often as clinically indicated. Review must be completed with the individual under the direction of a

licensed clinician and must include family, guardians, other supports as authorized by the individual

Clinical Services

- A family psychotherapy session must be completed within 7 days of admission
- While in the program, the individual must attend school. Individuals may be excused from school services if warranted due to severity of mental health or substance use symptoms or safety concerns. The reason for excusal must be documented
- Provide daily clinical services for a minimum of 25 hours per week. The amount, frequency, and intensity of services must be appropriate to individual needs and level of function as determined by the treating clinician and initial assessment. Interventions must include:
    - Individual psychotherapy: at least two sessions per week
    - Family psychotherapy: at least one session per week
    - Group psychotherapy: at least three sessions per week
    - Psychoeducational groups
    - Medication education
- Psychoeducational groups must be provided under the direction of licensed clinicians, and may be provided by licensed clinicians or direct care staff
- Medication education must be provided by a physician, APRN, pharmacist, PA, RN, or LPN under RN supervision Nursing care by an RN or LPN under RN supervision must be available 24 hours a day, 7 days a week. Nursing staff must be on call during sleep hours
- Weekly medication management with a psychiatrist or APRN with a specialty certification in psychiatry, including prescribing, delivery, administration and monitoring of adherence to medications
- Medication dispensing: All medications must be stored in a designated locked storage space and administered by a physician, registered nurse, licensed practical nurse or a medication aid under the direction and monitoring of an RN, PA, APRN, or Physician
- Treatment for co-occurring substance use disorder conditions must be provided as clinically indicated
- Use of restraint and seclusion must be in compliance with facility licensing requirements and federal requirements for restraint and seclusion in Psychiatric Residential Treatment Facilities

Support Services:

- The PRTF must have the ability to provide the following services as clinically indicated:
    - Laboratory
    - Medical

	• Physical, occupational, and speech therapy • Transportation services • Provide access to Medication Assisted Treatment (MAT) as medically appropriate • Provide consultation, referral, or both for medical, psychological, and psychopharmacology needs when these services cannot be rendered by program staff • Telephone or in-person consultation with a physician or APRN must be available 24 hours a day, 7 days a week • Assist the individual with accessing community supports and resources. The program must provide the following assistance as appropriate: • Coordinate with community resources on behalf of the individual • Assist with healthcare navigation • Coordinate with and facilitate access to external providers for individuals who require concurrent treatment • Assist individuals with application for and access to benefits and social support services • Assist individuals with reintegration into the community by identifying and connecting individuals with off-site vocational and educational resources **Discharge planning** • A family psychotherapy session must be completed within 7 days prior to discharge • Discharge planning is an ongoing process that occurs through the duration of service. A documented discharge plan must be completed as part of the Individualized Treatment, Rehabilitation, and Recovery Plan. • A transition plan must be completed prior to discharge. A copy of the transition plan must be given to the individual and to providers at the individual's next level of care, as applicable • The transition plan must identify the anticipated caregiver, what school the individual will attend, recommendations for the Individual Educational Plan (IEP), outline the aftercare plan, and identify potential barriers to the community reintegration and what is being done to address those barriers • The program must assist individuals with transition and discharge planning. The program must provide the following assistance as appropriate: • Assist individuals with identifying and accessing housing resources

	• Coordinate with community resources on behalf of individuals to facilitate successful reintegration into daily activity such as work, school, or family living as appropriate • Provide referrals and coordinate transition to a lower or higher level of care as clinically indicated • The program must contact the individual and the provider to which they were referred within 72 hours of discharge to ensure continuity of care. If the individual refuses referral or the program is unable to contact the individual this must be documented.
LENGTH OF SERVICE	Length of service is individualized and based on clinical criteria for admission and continuing stay. The anticipated duration of the service must be documented in the Individualized Treatment, Rehabilitation, and Recovery Plan
STAFFING	**Medical Director** Must have 2 years of experience in mental health disorder treatment Must be a: • Physician: child psychiatrist is preferable • Advanced Practice Registered Nurse (APRN) A consultant child psychiatrist must be available, if not in the Medical Director position **Clinical Director:** Must have experience or education in the diagnosis and treatment of mental illness. Must be one of the following: • Psychiatrist (preferred) • Physician • Advanced Practice Registered Nurse (APRN) • Physician Assistant (PA) • Psychologist • Licensed Independent Mental Health Practitioner (LIMHP) **Licensed Clinicians:** sufficient to meet staffing ratio **Licensed Nursing staff:** • Licensed Registered Nurse (RN) • Licensed Practical Nurse (LPN) **Direct Care Staff:** sufficient to meet staffing ratios **Optional staff may include:**

	Social Work staff: • Certified Social Worker (CSW) • Master Social Worker (MSW) • Provisionally Certified Master Social Worker (PCMSW) **Occupational Therapy staff:** • Licensed Occupational Therapist (OT) • Licensed Occupational Therapist Assistant (OTA) **Community Support/Peer Support staff:** • Community support worker • Certified peer support provider Peer support, community support, and medication management services, if provided by the program, are included in reimbursement and may not be separately reimbursed.
STAFFING RATIO	• Direct care staff to individual during day hours 1:4 • Awake direct care staff to individual during night hours 1:8 • A licensed clinician must be available on-call 24 hours a day. • Telephone or in-person consultation with a physician or APRN must be available 24 hours a day, 7 days a week • Nursing care by an RN or LPN under RN supervision must be available 24 hours a day, 7 days a week. Nursing staff must be on call during sleep hours
HOURS OF OPERATION	24 hours a day, 7 days a week
CONTINUED STAY REQUIREMENTS	All of the following criteria must be met for continuing treatment at this level of care: • The acuity of the individual's symptoms continues to necessitate treatment at the current level of care based on admission criteria • The individual does not require a more intensive level of services and no less intensive level of care is appropriate • The individual's treatment plan is up to date, with targets that are appropriate and related to improvement in the individual's symptoms and achievement of their goals. • The individual is making progress towards rehabilitation goals and they are showing progress towards symptom reduction as demonstrated by objective behavioral measurement of functional improvement or standardized report from the member or guardian of symptom and/or functional improvement.

	• If progress has not been made or symptoms are increased, the treatment plan has been modified to focus on any new symptoms or to address barriers to progress. • There is evidence that the treatment team is working towards a transition plan to meet the individual's treatment needs once this level of care is no longer appropriate.
DESIRED INDIVIDUAL OUTCOME	• The individual has substantially met the Individualized Treatment, Rehabilitation, and Recovery Plan goals and objectives • The precipitating condition and relapse potential is stabilized such that the individual's condition can be managed without this level of professional interventions • Individual has formal and informal support systems secured to maintain stability in a lower level of care • The individual is referred to ongoing treatment and recovery services

Therapeutic Group Home

Therapeutic Group Home (THGH) treatment provides 24-hour care in a home-like setting of no greater than 16 beds for youth aged 20 or younger. Services include an array of clinical treatment services and psychiatric supports within the THGH, and. promote integration with community resources and the development of adaptive and functional behaviors that enable the individual to be successful in family, school, work, and community environments. The program must allow ongoing participation of the individual's family. The program must facilitate involvement in community-based activities including educational, vocational, and rehabilitative activities. Treatment must focus on reducing the severity of the behavioral health issues that were identified as the reasons for admission.

SERVICE CATEGORY	Mental health
SETTING	Therapeutic Group Home (THGH) services must be provided in a home-like setting in a residential community of no greater than 16 beds
BILLING INFORMATION	Fee schedule code for this service is: • H2020 – Therapeutic Group Home (THGH) Psychotherapy services provided within a Therapeutic Group Home may be billed separately from the H2020 code for Therapeutic Group Home using the following codes: Individual psychotherapy: • 90832 - Individual Psychotherapy (30 minutes) • 90834 - Individual Psychotherapy (45 minutes) • 90837 - Individual Psychotherapy (60 minutes) Family psychotherapy: • 90846 - Family Psychotherapy, Individual Not Present • 90847 - Family Psychotherapy with Individual Present Group psychotherapy: • 90853 - Group Psychotherapy **Telehealth:** Services in residential and inpatient programs must be provided in person except as listed below. Elements of this service may be provided by telehealth as follows:

	Psychotherapy: Individual, group, and family psychotherapy may be provided via audiovisual telehealth for no more than 10% of psychotherapy services provided for each individual.

ADMISSION REQUIREMENTS	• Age: 20 years of age or younger
	• All of the following must be present:
	  ○ A primary diagnosis of a mental health disorder as outlined in the current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association
	  ○ The individual's symptoms are causing significant impairments in home, school and community functioning that can only be safely and effectively treated in a 24-hour setting with onsite behavioral health therapy
	  ○ THGH has been prescribed by a psychiatrist or psychologist who has documented that a residential setting is the least restrictive clinically appropriate service that can meet the specifically identified treatment needs of the individual
	  ○ Less restrictive community-based services have been given a fully adequate trial, and were unsuccessful or, if not attempted, have been considered, but in either situation was determined to be unable to meet the individual's treatment needs and the reasons for that are discussed in the application
	  ○ The individual does not require primary medical or surgical treatment
	  ○ THGH is not being used for clinically inappropriate reasons, including:
	  ▪ An alternative to incarceration, for preventative detention (e.g., to prevent running away or truancy), or as a means of ensuring community safety in an individual exhibiting primarily delinquent or antisocial behavior
	  ▪ The equivalent of safe housing or permanency placement
	  ▪ An alternative to parents', guardian's or agency's capacity to provide a place of residence for the individual
	  ▪ A treatment intervention, when other less restrictive alternatives are available

SERVICE EXPECTATIONS	**Assessments** • If an IDI was completed within 12 months prior to admission, and is determined to be clinically relevant, it may serve as the admission IDI. If there has been a gap in treatment of six months or more, or if there is new information available, an IDI addendum must be completed and may serve as the admission IDI

	• If an Initial Diagnostic Interview (IDI) has not been completed within the 12 months prior to admission, a new IDI or IDI addendum must be completed within 24 hours of the beginning of treatment. The IDI must meet the requirements as noted in the Initial Diagnostic Interview definition in this manual
	• A History and Physical (H&P) does not meet the requirements of this definition and may not substitute for an IDI.
	• Perform or refer for physical examination if the individual has not had a physical exam within the past 12 months. if completed by the program, the exam must be completed by a physician or APRN within 14 days of admission or sooner if indicated. Referrals must be completed within 14 days.
	
	Treatment Planning
	• An initial Treatment, Rehabilitation, and Recovery Plan must be developed within 24 hours of admission to guide the first seven days of treatment
	• Under clinical supervision, the individualized Treatment, Rehabilitation, and Recovery Plan, including discharge plan and relapse prevention must be developed with the individual within seven days of admission
	• Review and update the Individualized Treatment, Rehabilitation, and Recovery Plan every 30 days or more often as clinically indicated. Review must be completed with the individual under the direction of a licensed clinician and must include family, guardians, other supports as authorized by the individual
	
	Clinical Services
	• An APRN, RN, or LPN under RN supervision must be available in person or via telehealth 24 hours a day, 7 days a week
	• While in the program, the individual must attend a school in the community (e.g., a school integrated with children not from the program and not on the program's campus)
	• Provide daily clinical services for a minimum of 21 hours per week. The amount, frequency, and intensity of services must be appropriate to individual needs and level of function. Interventions must include:
	  • At least three hours per week of combined individual and group psychotherapy
	  • Family psychotherapy at least twice per month
	  • Psychoeducational groups

	• Medication education • Psychoeducational groups must be provided under the direction of licensed clinicians, and may be provided by licensed clinicians or direct care staff • Medication education, if provided, must be provided by a physician, APRN, pharmacist, PA, RN, or LPN under RN supervision The THGH must provide or have a documented formal agreement with qualified professionals to provide: • Psychological services • Dietary services • Medication management including prescribing, delivery, administration and monitoring of adherence to medications • Treatment for co-occurring substance use disorder conditions must be provided as clinically indicated • All medications must be stored in a designated locked storage space and administered by a physician, registered nurse, licensed practical nurse or a medication aid under the direction and monitoring of an RN, PA, APRN, or Physician **Support Services:** • Consultation, referral, or both for medical, psychological, substance use treatment, and psychopharmacology needs • Assist the individual with accessing community supports and resources. The program must provide the following assistance as appropriate: • Coordinate with the individual's school and educational supports • Coordinate with community resources on behalf of the individual • Assist with healthcare navigation • Coordinate with and facilitate access to external providers for individuals who require concurrent treatment • Assist individuals with application for and access to benefits and social support services • Assist individuals with reintegration into the community by identifying and connecting individuals with off-site vocational and educational resources • Optional: Peer support services **Discharge Planning** • Discharge planning is an ongoing process that occurs through the duration of service. A documented discharge plan must be completed as part of the Individualized Treatment, Rehabilitation, and Recovery Plan

	• A transition plan must be completed prior to discharge. A copy of the transition plan must be given to the individual and to providers at the individual's next level of care, as applicable
	• The program must assist individuals with transition and discharge planning. The program must provide the following assistance as appropriate:
	  • Assist individuals with identifying and accessing housing resources
	  • Coordinate with community resources, including the individual's school, on behalf of individuals to facilitate successful reintegration into daily activity
	  • Provide referrals and coordinate transition to a lower or higher level of care as clinically indicated
	• The program must contact the individual and the provider to which they were referred within 72 hours of discharge to ensure continuity of care. If the individual refuses referral or the program is unable to contact the individual this must be documented.

LENGTH OF SERVICE	Length of service is individualized and based on clinical criteria for admission and continuing stay. The anticipated duration of the service must be documented in the Individualized Treatment, Rehabilitation, and Recovery Plan
STAFFING	**Clinical Director** Must be one of the following: • Psychiatrist • Physician • Psychologist • Advanced Practice Registered Nurse (APRN) • Physician Assistant (PA) • Licensed Independent Mental Health Practitioner (LIMHP) • Licensed Mental Health Practitioner (LMHP) **Licensed Clinicians:** Sufficient to meet staffing ratio **Licensed Nursing staff** Must include at least one of the following: • Advanced Practice Registered Nurse (APRN) • Licensed Registered Nurse (RN) • Licensed Practical Nurse (LPN) **Direct Care Staff:** Sufficient to meet staffing ratio

	Optional staff may include: • Community support worker • Certified peer support provider Peer support, community support, and medication management services, if provided by the program, are included in reimbursement and may not be separately
STAFFING RATIO	Licensed clinician to individual 1:12 Direct care staff to individual during day hours: 1:6. Minimum of two staff per day shift. Awake staff to individual during night hours 1:8 A licensed clinician must be available on-call 24 hours a day
HOURS OF OPERATION	24 hours a day, 7 days per week The program must ensure the presence and availability of licensed clinical staff on some nights and weekends, when parents are available to participate in family therapy and to provide input on the treatment of the individual
CONTINUED STAY REQUIREMENTS	All of the following criteria must be met for continuing treatment at this level of care: • The acuity of the individual's symptoms continues to necessitate treatment at the current level of care based on admission criteria • The individual does not require a more intensive level of services and no less intensive level of care is appropriate • The individual's treatment plan is up to date, with targets that are appropriate and related to improvement in the individual's symptoms and achievement of their goals. • The individual is making progress towards rehabilitation goals and they are showing progress towards symptom reduction as demonstrated by objective behavioral measurement of functional improvement or standardized report from the member or guardian of symptom and/or functional improvement. • If progress has not been made or symptoms are increased, the treatment plan has been modified to focus on any new symptoms or to address barriers to progress. • There is evidence that the treatment team is working towards a transition plan to meet the individual's treatment needs once this level of care is no longer appropriate.

DESIRED INDIVIDUAL OUTCOME	• The individual has substantially met the Individualized Treatment, Rehabilitation, and Recovery Plan goals and objectives • The precipitating condition and relapse potential is stabilized such that the individual's condition can be managed without this level of professional interventions • Individual has formal and informal support systems secured to maintain stability in a lower level of care

Secure Psychiatric Residential Treatment

Secure Psychiatric Residential treatment is intended to provide individualized recovery, psychiatric rehabilitation, and support as determined by additional clinically appropriate assessments for individuals with a mental illness, with or without a co-occurring substance use disorder, demonstrating a moderate to high-risk for harm to self or others and in need of a secure recovery, rehabilitative, and therapeutic environment

SERVICE CATEGORY	Mental health
SETTING	• Facility – must be secured
BILLING INFORMATION	Fee schedule code for this service is: • H2018 HK – Secure Psychiatric Residential Rehabilitation Services ○ This code is per diem, including daily room and board **Telehealth:** Services in residential and inpatient programs must be provided in person except as listed below. Elements of this service may be provided by telehealth as follows: **PSYCHOTHERAPY:** Individual, group, and family psychotherapy may be provided via audiovisual telehealth for no more than 10% of psychotherapy services provided for each individual.

ADMISSION REQUIREMENTS	• Age: 21 years of age or older – for youth eligibility, refer to EPSDT requirements as outlined in the definition section of this manual.
	• The individual meets criteria for a severe mental illness as evidenced by functional limitations related to the diagnosis that seriously interfere with the individual's ability to function independently in an appropriate manner in two of three functional areas:
	  ○ Instrumental activities of daily living: inability to be employed or an ability to be employed only with extensive supports; deterioration or decompensation resulting in inability to establish or pursue educational goals within normal time frame or without extensive supports; or inability to consistently and independently carry out home management tasks
	  ○ Social functioning: repeated inappropriate or inadequate social behavior or ability to behave appropriately only with extensive supports; or consistent participation in adult activities only with extensive supports or when involvement is mostly limited to special activities established for persons with mental illness; or history of dangerousness to self or others
	  ○ Activities of daily living: inability to consistently perform the range of practical daily living tasks required for basic adult functioning as evidenced by functional limitations in at least three of the following areas:
	  ▪ Grooming, hygiene, washing clothes, meeting nutritional needs
	  ▪ Care of personal business affairs
	  ▪ Transportation and care of residence
	  ▪ Procurement of medical, legal, and housing services
	  ▪ Recognition and avoidance of common dangers or hazards to self and possessions
	• Individual's functional deficits are of such intensity that a 24-hour secure psychiatric residential setting is required to ensure the individual's safety
	• The individual is at significant risk of continuing in a pattern of either institutionalization or living in a severely dysfunctional manner if needed rehabilitation services are not provided, as evidenced by impaired function in one additional functional area listed above. Symptoms and functional deficits are related to the primary diagnosis.
	• Requires 24-hour awake staff to assist with psychiatric rehabilitation.
	• The individual has a moderate to high risk of relapse or symptoms reoccurrence, as evidenced by the following (must meet ALL criteria):
	  • Active symptomology consistent with Diagnostic and Statistical Manual (DSM), current edition, diagnoses
	  • High need for professional structure, intervention and observation
	  • Moderate to high risk for re-hospitalization without 24-hour supervision, and

	• Unable to safely reside in less restrictive residential setting and requires 24-hour supervision Must meet one of the following two criteria: 1) Moderate to high risk of danger to self as a product of the principal DSM, current edition, diagnosis, as evidenced by any of the following: • Attempts to harm self, which are life threatening or could cause disabling permanent damages with continued risk without 24-hour behavioral monitoring • Suicidal ideation • A level of suicidality that cannot be safely managed without 24-hour behavioral monitoring • At risk for severe self-neglect resulting in harm or injury 2) Moderate to high risk of danger to others, as a product of the principal DSM, current edition, diagnosis, as evidenced by any of the following: • Life threatening action with continued risk without 24-hour behavioral supervision and intervention • Harmful ideation
SERVICE EXPECTATIONS	**Assessments** • A nursing assessment by an RN, or LPN under RN supervision, must be completed within 24 hours of admission with recommendations for further in-depth physical examination as indicated • A physical assessment by a physician, physician assistant (PA), or advanced practice registered nurse (APRN) must be completed within 24 hours of admission, or earlier if medically necessary. If a physical exam has been performed within the preceding 90 days, that exam must be reviewed by the physician • The assessment must evaluate any potential medical causes of the individual's symptoms • If an IDI was completed within 12 months prior to admission, and is determined to be clinically relevant, it may serve as the admission IDI. If there has been a gap in treatment of six months or more, or if there is new information available, an IDI addendum must be completed and may serve as the admission IDI • If an Initial Diagnostic Interview (IDI) has not been completed within the 12 months prior to admission, a new IDI or IDI addendum must be completed within 24 hours of the beginning of treatment. The IDI must meet the requirements as noted in the Initial Diagnostic Interview definition in this manual • A History and Physical (H&P) does not meet the requirements of this definition and may not substitute for an IDI.

	• Consistent with the Admission Requirements, a baseline of functional status should be established by standardized assessment of Instrumental Activities of Daily Living, Social function and basic Activities of Daily Living
	
	Treatment Planning
	• An initial Treatment, Rehabilitation, and Recovery Plan must be developed within 24 hours of admission to guide the first seven days of treatment
	• Under clinical supervision, the individualized Treatment, Rehabilitation, and Recovery Plan, including discharge plan and relapse prevention must be developed with the individual within seven days of admission
	• Review and update the Individualized Treatment, Rehabilitation, and Recovery Plan every 30 days or more often as clinically indicated. Review must be completed with the individual under the direction of a licensed clinician and must include family, guardians, other supports as authorized by the individual
	
	Clinical Services
	• A psychiatrist must evaluate the individual in-person every 7 days and more frequently if needed
	• Nursing services must be available 24 hours per day on site or on call
	• Provide daily clinical services for a minimum of 42 hours per week. The amount, frequency, and intensity of services must be appropriate to individual needs and level of function. Interventions must include:
	  • Individual, family, and group psychotherapy
	  • Psychoeducational groups
	  • Medication education
	• Psychoeducational groups must be provided under the direction of licensed clinicians, and may be provided by licensed clinicians or direct care staff
	• Medication education must be provided by a physician, APRN, pharmacist, PA, RN, or LPN under RN supervision Treatment for co-occurring substance use disorder conditions must be provided as clinically indicated
	• All medications must be stored in a designated locked storage space and administered by a physician, registered nurse, licensed practical nurse or a medication aid under the direction and monitoring of an RN, PA, APRN, or Physician
	
	Support Services
	• Provide access to Medication Assisted Treatment (MAT) as medically appropriate

	• Consultation, referral, or both for medical, psychological, and psychopharmacology needs
	• Assist the individual with accessing community supports and resources. The program must provide the following assistance as appropriate:
	  • Coordinate with community resources on behalf of the individual
	  • Assist with healthcare navigation
	  • Coordinate with and facilitate access to external providers for individuals who require concurrent treatment
	  • Assist individuals with application for and access to benefits and social support services
	  • Assist individuals with reintegration into the community by identifying and connecting individuals with off-site vocational and educational resources
	
	Discharge Planning
	• Discharge planning is an ongoing process that occurs through the duration of service. A documented discharge plan must be completed as part of the individualized Treatment, Rehabilitation, and Recovery Plan
	• A transition plan must be completed prior to discharge. A copy of the transition plan must be given to the individual and to providers at the individual's next level of care, as applicable
	• The program must assist individuals with transition and discharge planning. The program must provide the following assistance as appropriate:
	  • Assist individuals with identifying and accessing housing resources
	  • Coordinate with community resources on behalf of individuals to facilitate successful reintegration into daily activity such as work, school, or family living as appropriate
	  • Provide referrals and coordinate transition to a lower or higher level of care as clinically indicated
	• The program must contact the individual and the provider to which they were referred within 72 hours of discharge to ensure continuity of care. If the individual refuses referral or the program is unable to contact the individual this must be documented.

LENGTH OF SERVICE	Length of service is individualized and based on clinical criteria for admission and continuing stay. The anticipated duration of the service must be documented in the individualized Treatment, Rehabilitation, and Recovery Plan

STAFFING	**Clinical Director:** Must be one of the following: • Psychiatrist • Physician • Advanced Practice Registered Nurse (APRN) • Physician Assistant (PA) • Psychologist • Licensed Independent Mental Health Practitioner (LIMHP) • Licensed Mental Health Practitioner (LMHP) If not in the clinical director position, the program must have a formal consultative agreement with a licensed psychiatrist. **Licensed Clinicians:** sufficient to meet staffing ratio **Licensed Nursing staff:** • Licensed Registered Nurse (RN) • Licensed Practical Nurse (LPN) **Direct Care Staff:** Sufficient to meet staffing ratio **Optional staff may include:** • Community support worker • Certified peer support provider Peer support, community support, and medication management services, if provided by the program, are included in reimbursement and may not be separately.
STAFFING RATIO	Licensed clinician to individual 1:8 Direct care staff to individual during day hours 1:4 Awake staff to individuals during night hours 1:6 A licensed medical provider and a licensed clinician must be available on-call 24 hours a day
HOURS OF OPERATION	24 hours a day, 7 days a week
CONTINUED STAY REQUIREMENTS	All of the following criteria must be met for continuing treatment at this level of care: • The acuity of the individual's symptoms continues to necessitate treatment at the current level of care based on admission criteria

	• The individual does not require a more intensive level of services and no less intensive level of care is appropriate • The individual's treatment plan is up to date, with targets that are appropriate and related to improvement in the individual's symptoms and achievement of their goals. • The individual is making progress towards rehabilitation goals and they are showing progress towards symptom reduction as demonstrated by objective behavioral measurement of functional improvement or standardized report from the member or guardian of symptom and/or functional improvement. • If progress has not been made or symptoms are increased, the treatment plan has been modified to focus on any new symptoms or to address barriers to progress. • There is evidence that the treatment team is working towards a transition plan to meet the individual's treatment needs once this level of care is no longer appropriate.
DESIRED INDIVIDUAL OUTCOME	• The individual meets the goals and objectives of the treatment plan • The precipitating condition has stabilized such that the individual's condition can be managed with decreased professional supports and interventions • The individual is referred to ongoing treatment and recovery services • The individual has support systems in place to help the individual maintain stability in the community

Residential Services – SUD

Adult SUD Clinically Managed Low-Intensity Residential Treatment - ASAM 3.1

Clinically Managed Low-Intensity Residential Treatment (formerly Halfway House) provides transitional, 24-hour structured supportive living and treatment for individuals seeking reintegration into the community, often after primary treatment at a more intensive level. This service provides safe housing, structured therapeutic engagement (Individual, group and family therapy) and support, affording individuals an opportunity to develop and practice interpersonal, sober living, and recovery skills while reintegrating into their community. Individuals may also access off-site vocational, educational, and rehabilitative activities during daytime hours. Services align with current edition ASAM 3.1 guidance.

SERVICE CATEGORY	Substance use disorder
SETTING	• Facility
BILLING INFORMATION	Fee schedule code for this service is: • H2034 – ASAM Level 3.1 – Clinically Managed Low-Intensity Residential **Telehealth:** Services in residential and inpatient programs must be provided in person except as listed below. Elements of this service may be provided by telehealth as follows: **PSYCHOTHERAPY:** Individual, group, and family psychotherapy may be provided via audiovisual telehealth for no more than 10% of psychotherapy services provided for each individual.
ADMISSION REQUIREMENTS	• Age: 21 years of age or older – for youth eligibility, refer to EPSDT requirements as outlined in the definition section of this manual. • The individual demonstrates symptomatology consistent with a substance use disorder diagnosis as outlined in the current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders

	published by the American Psychiatric Association, which requires and can reasonably be expected to respond to therapeutic intervention • The individual meets applicable dimensional criteria for admission to this service according to the American Society of Addiction Medicine (ASAM), 4th edition criteria It is expected that the individual will be able to benefit from this treatment • This level of care is the least restrictive setting that will produce the desired results in accordance with the needs of the individual
SERVICE EXPECTATIONS	**Assessments** • If an IDI was completed within 12 months prior to admission, and is determined to be clinically relevant, it may serve as the admission IDI. If there has been a gap in treatment of six months or more, or if there is new information available, an IDI addendum must be completed and may serve as the admission IDI • If an Initial Diagnostic Interview (IDI) has not been completed within the 12 months prior to admission, a new IDI or IDI addendum must be completed within 24 hours of the beginning of treatment. The IDI must meet the requirements as noted in the Initial Diagnostic Interview definition in this manual *If the licensed clinician completing the IDI cannot diagnose substance use disorders within their professional competencies, a substance use disorder (SUD) assessment must also be completed. If an individual is being treated for a substance use disorder only, an SUD assessment may be completed as a substitute for an IDI:* ○ If an SUD assessment was completed within 12 months prior to admission to the service, and is determined to be clinically relevant, it can serve as the SUD assessment. If there has been a gap in treatment of six months or more, or if there is new information available, an SUD addendum must be completed and may serve as the SUD assessment ○ If an SUD assessment has not been completed within the 12 months prior to admission, a new SUD assessment or addendum must be completed within 24 hours of the beginning of treatment and must establish the need for this service. The SUD assessment must meet the requirements outlined in the SUD Assessment definition in this manual • A History and Physical (H&P) does not meet the requirements of this definition and may not substitute for an SUD assessment. • Perform or refer for physical examination if the individual has not had a physical exam within the past 12 months. If performed by the

program, the exam must be completed by a physician or APRN within 14 days of admission or sooner if indicated. The examination should include assessment for addiction medication needs. Referrals must be completed within 14 days.

Treatment Planning

- An initial treatment plan must be developed within 24 hours of admission to guide the first 14 days of treatment
- Under clinical supervision, develop an Individualized Treatment, Rehabilitation, and Recovery Plan, including discharge plan and relapse prevention, with the individual within 14 days of admission
- Review and update the Individualized Treatment, Rehabilitation, and Recovery Plan every 30 days or more often as clinically indicated. Review must be completed with the individual under the direction of a licensed clinician and must include family, guardians, other supports as authorized by the individual

Clinical Services

- Provide daily clinical services for a minimum of 9 hours per week. The amount, frequency, and intensity of services must be appropriate to individual needs and level of function as determined by ASAM criteria and assessment. Interventions must be provided in accordance with ASAM guidelines, and must include:
    - Individual, family, and group psychotherapy
    - Psychoeducational groups
- Psychoeducational groups must be provided under the direction of licensed clinicians, and may be provided by licensed clinicians or direct care staff
- Pharmaceutical services: If medications are dispensed by the program, all medications must be stored in a designated locked storage space and administered by a physician, registered nurse, licensed practical nurse or a medication aid under the direction and monitoring of an RN, PA, APRN, or Physician

Support Services

- Provide access to Medication Assisted Treatment (MAT) as medically appropriate
- Consultation, referral, or both for medical, psychological, and psychopharmacology needs
- Assist the individual with accessing community supports and resources. The program must provide the following assistance as appropriate:

	○ Coordinate with community resources on behalf of the individual ○ Assist with healthcare navigation ○ Coordinate with and facilitate access to external providers for individuals who require concurrent treatment ○ Assist individuals with application for and access to benefits and social support services ○ Assist individuals with reintegration into the community by identifying and connecting individuals with off-site vocational and educational resources **Discharge Planning** • Discharge planning is an ongoing process that occurs through the duration of service. A documented discharge plan must be completed as part of the Individualized Treatment, Rehabilitation, and Recovery Plan • A transition plan must be completed prior to discharge. A copy of the transition plan must be given to the individual and to providers at the individual's next level of care, as applicable • The program must assist individuals with transition and discharge planning. The program must provide the following assistance as appropriate: ○ Assist individuals with identifying and accessing housing resources ○ Coordinate with community resources on behalf of individuals to facilitate successful reintegration into daily activity such as work, school, or family living as appropriate ○ Provide referrals and coordinate transition to a lower or higher level of care as clinically indicated • The program must contact the individual and the provider to which they were referred within 72 hours of discharge to ensure continuity of care. If the individual refuses referral or the program is unable to contact the individual this must be documented.
LENGTH OF SERVICE	Length of service is individualized and based on clinical criteria for admission and continuing stay. The anticipated duration of the service must be documented in the Individualized Treatment, Rehabilitation, and Recovery Plan
STAFFING	**Clinical Director** Must have five years of experience in substance use disorder treatment Must be one of the following:

	• Psychiatrist • Physician • Psychologist • Advanced Practice Registered Nurse (APRN) • Physician Assistant (PA) • Registered Nurse (RN) • Licensed Independent Mental Health Practitioner (LIMHP) • Licensed Mental Health Practitioner (LMHP) • Licensed Drug and Alcohol Counselor (LADC) **Licensed Clinicians:** sufficient to meet staffing ratios **Direct Care staff:** sufficient to meet staffing ratios **Optional staff may include:** • Community support worker • Certified peer support provider Peer support, community support, and medication management services, if provided by the program, are included in program reimbursement and may not be separately reimbursed. All program staff must complete training in overdose prevention and administration of opioid overdose reversal medications. The program must maintain an overdose response protocol Overdose reversal medications must be available at the facility at all times.
STAFFING RATIO	**Licensed clinicians:** Licensed clinician to individual 1:12 **Direct care staff:** Direct care staff to individual during day hours 1:10 Awake staff to individual during night hours 1:12 A licensed clinician must be available on-call 24 hours a day
HOURS OF OPERATION	24 hours a day, 7 days a week
CONTINUED STAY REQUIREMENTS	All of the following criteria must be met for continuing treatment at this level of care: • The acuity of the individual's symptoms continues to necessitate treatment at the current level of care based on admission criteria and ASAM guidelines

	• The individual does not require a more intensive level of services and no less intensive level of care is appropriate • The individual's treatment plan is up to date, with targets that are appropriate and related to improvement in the individual's symptoms and achievement of their goals. • The individual is making progress towards rehabilitation goals and they are showing progress towards symptom reduction as demonstrated by review of ASAM criteria, objective behavioral measurement of functional improvement, or standardized report from the member or guardian of symptom and/or functional improvement. • If progress has not been made or symptoms are increased, the treatment plan has been modified to focus on any new symptoms or to address barriers to progress. • There is evidence that the treatment team is working towards a transition plan to meet the individual's treatment needs once this level of care is no longer appropriate.
DESIRED INDIVIDUAL OUTCOME	• The individual has substantially met the treatment, recovery, and rehabilitation plan goals and objectives • The precipitating condition and relapse potential is stabilized such that there is sustained improvement in health and psychosocial functioning • The individual's condition can be managed without the professional external supports and intervention at this level of care • The individual has alternative support systems secured to help maintain active recovery and stability in the community • The individual is connected to the next appropriate level of care necessary to treat the condition

Adult SUD Therapeutic Community - ASAM 3.1

Therapeutic Community provides 24-hour care in a live-in setting. It is intended for individuals with a primary substance use disorder who need substance use treatment in a safe and stable living environment. Services are focused on psychosocial skill building through a set of longer term, highly structured peer-oriented treatment activities which define progress toward individual change and rehabilitation, and which incorporate a series of clear phases. The individual's progress must be marked by advancement through these phases to less restrictiveness and more personal responsibility. Therapeutic Community relies on group accountability and support. Services align with current edition ASAM level 3.1 guidance.

SERVICE CATEGORY	Substance use disorder
SETTING	• Facility
BILLING INFORMATION	Fee schedule code for this service is: • H2034: ASAM Level 3.1 – Adult SUD Therapeutic Community ○ This code is per diem, not including daily room and board **Telehealth:** Services in residential and inpatient programs must be provided in person except as listed below. Elements of this service may be provided by telehealth as follows: **PSYCHOTHERAPY:** Individual, group, and family psychotherapy may be provided via audiovisual telehealth for no more than 10% of psychotherapy services provided for each individual.
ADMISSION REQUIREMENTS	• Age: 21 years of age and older – for youth eligibility, refer to EPSDT requirements as outlined in the definition section of this manual. • The individual demonstrates symptomatology consistent with a substance use disorder diagnosis as outlined in the current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders

	published by the American Psychiatric Association, which requires and can reasonably be expected to respond to therapeutic intervention • The individual meets applicable dimensional criteria for admission to this service according to the American Society of Addiction Medicine (ASAM), 4th edition criteria It is expected that the individual will be able to benefit from this treatment • This level of care is the least restrictive setting that will produce the desired results in accordance with the needs of the individual
SERVICE EXPECTATIONS	**Assessments** • If an IDI was completed within 12 months prior to admission, and is determined to be clinically relevant, it may serve as the admission IDI. If there has been a gap in treatment of six months or more, or if there is new information available, an IDI addendum must be completed and may serve as the admission IDI • If an Initial Diagnostic Interview (IDI) has not been completed within the 12 months prior to admission, a new IDI or IDI addendum must be completed within 24 hours of the beginning of treatment. The IDI must meet the requirements as noted in the Initial Diagnostic Interview definition in this manual *If the licensed clinician completing the IDI cannot diagnose substance use disorders within their professional competencies, a substance use disorder (SUD) assessment must also be completed. If an individual is being treated for a substance use disorder only, an SUD assessment may be completed as a substitute for an IDI:* ○ If an SUD assessment was completed within 12 months prior to admission to the service, and is determined to be clinically relevant, it can serve as the SUD assessment. If there has been a gap in treatment of six months or more, or if there is new information available, an SUD addendum must be completed and may serve as the SUD assessment. ○ If an SUD assessment has not been completed within the 12 months prior to admission, a new SUD assessment or addendum must be completed within 24 hours of the beginning of treatment and must establish the need for this service. The SUD assessment must meet the requirements outlined in the SUD Assessment definition in this manual • A History and Physical (H&P) does not meet the requirements of this definition and may not substitute for an SUD assessment. • Perform or refer for physical examination, including a withdrawal management assessment, if the individual has not had a physical

exam within the past 12 months. if completed by the program, the exam must be completed by a physician or APRN within 14 days of admission or sooner if indicated. Referrals must be completed within 14 days.

Treatment Planning

- An initial Treatment, Rehabilitation, and Recovery Plan must be developed within 24 hours of admission to guide the first seven days of treatment
- Under clinical supervision, the individualized Treatment, Rehabilitation, and Recovery Plan, including discharge plan and relapse prevention must be developed with the individual within seven days of admission
- Review and update the individualized Treatment, Rehabilitation, and Recovery Plan every 30 days or more often as clinically indicated. Review must be completed with the individual under the direction of a licensed clinician and must include family, guardians, and other supports as authorized by the individual

Clinical Services

- Provide daily clinical services for a minimum of 19 hours per week. The amount, frequency, and intensity of services must be appropriate to individual needs and level of function as determined by ASAM criteria and assessment. Clinical services must be provided in accordance with ASAM guidelines, and must include:
    - Individual, family, and group psychotherapy
    - Psychoeducational groups
- Psychoeducational groups must be provided under the direction of licensed clinicians, and may be provided by licensed clinicians or direct care staff
- Medication dispensing: All medications must be stored in a designated locked storage space and administered by a physician, registered nurse, licensed practical nurse or a medication aid under the direction and monitoring of an RN, PA, APRN, or Physician

Support Services

- Provide access to Medication Assisted Treatment (MAT) as medically appropriate
- Provide consultation, referral, or both for medical, psychological, and psychopharmacology needs
- Telephone or in-person consultation with a physician or APRN must be available 24 hours a day, 7 days a week
- Peer support services

	• Assist the individual with accessing community supports and resources. The program must provide the following assistance as appropriate:
	  ○ Coordinate with community resources on behalf of the individual
	  ○ Assist with healthcare navigation
	  ○ Coordinate with and facilitate access to external providers for individuals who require concurrent treatment
	  ○ Assist individuals with application for and access to benefits and social support services
	  ○ Assist individuals with reintegration into the community by identifying and connecting individuals with off-site vocational, educational, and rehabilitative resources
	
	Discharge Planning
	• Discharge planning is an ongoing process that occurs through the duration of service. A documented discharge plan must be completed as part of the individualized Treatment, Rehabilitation, and Recovery Plan
	• A transition plan must be completed prior to discharge. A copy of the transition plan must be given to the individual and to providers at the individual's next level of care, as applicable
	• The program must assist individuals with transition and discharge planning. The program must provide the following assistance as appropriate:
	  ○ Assist individuals with identifying and accessing housing resources
	  ○ Coordinate with community resources on behalf of individuals to facilitate successful reintegration into daily activity such as work, school, or family living as appropriate
	  ○ Provide referrals and coordinate transition to a lower or higher level of care as clinically indicated
	• The program must contact the individual and the provider to which they were referred within 72 hours of discharge to ensure continuity of care. If the individual refuses referral or the program is unable to contact the individual this must be documented.

LENGTH OF SERVICE	Length of service is individualized and based on clinical criteria for admission and continuing stay. The anticipated duration of the service must be documented in the Treatment, Rehabilitation, and Recovery Plan
STAFFING	**Clinical Director:** Must have five years of experience in substance use disorder treatment Must be one of the following:

	• Psychiatrist • Physician • Psychologist • Advanced Practice Registered Nurse (APRN) • Physician Assistant (PA) • Registered Nurse (RN) • Licensed Independent Mental Health Practitioner (LIMHP) • Licensed Mental Health Practitioner • Licensed Drug and Alcohol Counselor (LADC) **Licensed Clinicians:** Sufficient to meet staffing ratio **Direct Care staff:** Sufficient to meet staffing ratio **Optional staff may include:** • Community support worker • Certified peer support provider Peer support, community support, and medication management services, if provided by the program, are included in reimbursement and may not be separately reimbursed All program staff must complete training in overdose prevention and administration of opioid overdose reversal medications. The program must maintain an overdose response protocol Overdose reversal medications must be available at the facility at all times.
STAFFING RATIO	Therapist to individual 1:10 Direct care staff to individual during day hours: 1:10 Awake staff to individual during night hours 1:10 A licensed clinician must be available on-call 24 hours a day
HOURS OF OPERATION	24 hours a day, 7 days a week
CONTINUED STAY REQUIREMENTS	All of the following criteria must be met for continuing treatment at this level of care: • The acuity of the individual's symptoms continues to necessitate treatment at the current level of care based on admission criteria and ASAM guidelines • The individual does not require a more intensive level of services and no less intensive level of care is appropriate

	• The individual's treatment plan is up to date, with targets that are appropriate and related to improvement in the individual's symptoms and achievement of their goals. • The individual is making progress towards rehabilitation goals and they are showing progress towards symptom reduction as demonstrated by review of ASAM criteria, objective behavioral measurement of functional improvement, or standardized report from the member or guardian of symptom and/or functional improvement. • If progress has not been made or symptoms are increased, the treatment plan has been modified to focus on any new symptoms or to address barriers to progress. • There is evidence that the treatment team is working towards a transition plan to meet the individual's treatment needs once this level of care is no longer appropriate.
DESIRED INDIVIDUAL OUTCOMES	• The individual has substantially met the Treatment, Rehabilitation, and Recovery Plan goals and objectives • The precipitating condition and relapse potential is stabilized such that there is sustained improvement in health and psychosocial functioning • The individual's condition can be managed without the professional external supports and intervention at this level of care • The individual has alternative support systems secured to help maintain active recovery and stability in the community • The individual is connected to the next appropriate level of care necessary to treat the condition

Adult SUD Intermediate Therapeutic Residential Treatment - ASAM 3.1 (co-occurring capable)

Intermediate Therapeutic Residential Treatment provides 24-hour care in a live-in setting. It is intended for individuals with a primary substance use disorder for whom less intensive treatment is inappropriate, either because of the pervasiveness of the impact of substance use on the individual's life or because of a significant history of repeated short-term or less restrictive treatment. Services are highly structured and focused, and provide a high level of support. Programming is characterized by slower paced interventions; purposefully repetitive to meet special individual treatment needs. Services align with current edition ASAM Level 3.1 guidance

SERVICE CATEGORY	Substance use disorder
SETTING	• Facility
BILLING INFORMATION	Fee schedule code for this service is: • H0019: ASAM Level 3.1 – Adult Intermediate Therapeutic Residential, Co-occurring capable ○ This code is per diem. Room and board are not included. **Telehealth:** Services in residential and inpatient programs must be provided in person except as listed below. Elements of this service may be provided by telehealth as follows: **PSYCHOTHERAPY:** Individual, group, and family psychotherapy may be provided via audiovisual telehealth for no more than 10% of psychotherapy services provided for each individual.
ADMISSION REQUIREMENTS	• Age: 21 years of age and older – for youth eligibility, refer to EPSDT requirements as outlined in the definition section of this manual.

	• The individual demonstrates symptomatology consistent with a substance use disorder diagnosis as outlined in the current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association, which requires and can reasonably be expected to respond to therapeutic intervention • The individual meets applicable dimensional criteria for admission to this service according to the American Society of Addiction Medicine (ASAM), 4th edition criteria Individuals in an ASAM Level 3.1 co-occurring capable programs may have co-occurring mental disorders that meet the stability criteria for placement in a co-occurring capable program; or difficulties with mood, behavior or cognition related to a substance use or mental disorder; or emotional, behavioral or cognitive symptoms that are troublesome but do not meet current edition DSM criteria for a severe and persistent mental disorder • It is expected that the individual will be able to benefit from this treatment • This level of care is the least restrictive setting that will produce the desired results in accordance with the needs of the individual
SERVICE EXPECTATIONS	**Assessments** • If an IDI was completed within 12 months prior to admission, and is determined to be clinically relevant, it may serve as the admission IDI. If there has been a gap in treatment of six months or more, or if there is new information available, an IDI addendum must be completed and may serve as the admission IDI • If an Initial Diagnostic Interview (IDI) has not been completed within the 12 months prior to admission, a new IDI or IDI addendum must be completed within 24 hours of the beginning of treatment. The IDI must meet the requirements as noted in the Initial Diagnostic Interview definition in this manual *If the licensed clinician completing the IDI cannot diagnose substance use disorders within their professional competencies, a substance use disorder (SUD) assessment must also be completed. If an individual is being treated for a substance use disorder only, an SUD assessment may be completed as a substitute for an IDI:* ○ If an SUD assessment was completed within 12 months prior to admission to the service, and is determined to be clinically relevant, it can serve as the SUD assessment. If there has been a gap in treatment of six months or more, or if there is new information available, an SUD addendum must be completed and may serve as the SUD assessment

	○ If an SUD assessment has not been completed within the 12 months prior to admission, a new SUD assessment or addendum must be completed within 24 hours of the beginning of treatment and must establish the need for this service. The SUD assessment must meet the requirements outlined in the SUD Assessment definition in this manual • A History and Physical (H&P) does not meet the requirements of this definition and may not substitute for an SUD assessment. • Perform or refer for physical examination if the individual has not had a physical exam within the past 12 months. if completed by the program, the exam must be completed by a physician or APRN within 14 days of admission or sooner if indicated. The examination should include assessment for addiction medication needs. Referrals must be completed within 14 days. • A nursing assessment by an RN, or LPN under RN supervision must be completed within 24 hours of admission with recommendations for further in-depth physical examination as indicated **Treatment Planning** • An initial Treatment, Rehabilitation, and Recovery Plan must be developed within 24 hours of admission to guide the first seven days of treatment • Under clinical supervision, the Individualized Treatment, Rehabilitation, and Recovery Plan, including discharge plan and relapse prevention must be developed with the individual within seven days of admission • Review and update the Individualized Treatment, Rehabilitation, and Recovery Plan every 30 days or more often as clinically indicated. Review must be completed with the individual under the direction of a licensed clinician and must include family, guardians, other supports as authorized by the individual **Clinical Services** • Provide daily clinical services for a minimum of 30 hours per week. The amount, frequency, and intensity of services must be appropriate to individual needs and level of function as determined by ASAM criteria and assessment. Interventions must be provided in accordance with ASAM guidelines, and must include: ○ Individual, family, and group psychotherapy ○ Psychoeducational groups • Psychoeducational groups must be provided under the direction of licensed clinicians, and may be provided by licensed clinicians or direct care staff

	• Individual psychiatric services must be provided as clinically indicated consistent with co-occurring diagnosis capable treatment, including treatment of co-occurring mental health conditions
	• Pharmaceutical services: All medications must be stored in a designated locked storage space and administered by a physician, registered nurse, licensed practical nurse or a medication aid under the direction and monitoring of an RN, PA, APRN, or Physician.
	
	Support Services
	• Provide access to Medication Assisted Treatment (MAT) as medically appropriate
	• Consultation, referral, or both for medical, psychological, and psychopharmacology needs
	• Assist the individual with accessing community supports and resources. The program must provide the following assistance as appropriate:
	  ○ Coordinate with community resources on behalf of the individual
	  ○ Assist with healthcare navigation
	  ○ Coordinate with and facilitate access to external providers for individuals who require concurrent treatment
	  ○ Assist individuals with application for and access to benefits and social support services
	  ○ Assist individuals with reintegration into the community by identifying and connecting individuals with off-site vocational and educational resources
	
	Discharge Planning
	• Discharge planning is an ongoing process that occurs through the duration of service. A documented discharge plan must be completed as part of the Individualized Treatment, Rehabilitation, and Recovery Plan
	• A transition plan must be completed prior to discharge. A copy of the transition plan must be given to the individual and to providers at the individual's next level of care, as applicable
	• The program must assist individuals with transition and discharge planning. The program must provide the following assistance as appropriate:
	  ○ Assist individuals with identifying and accessing housing resources
	  ○ Coordinate with community resources on behalf of individuals to facilitate successful reintegration into daily activity such as work, school, or family living as appropriate

	○ Provide referrals and coordinate transition to a lower or higher level of care as clinically indicated • The program must contact the individual and the provider to which they were referred within 72 hours of discharge to ensure continuity of care. If the individual refuses referral or the program is unable to contact the individual this must be documented.
LENGTH OF SERVICE	Length of service is individualized and based on clinical criteria for admission and continued stay. The anticipated duration of the service must be documented in the Individualized Treatment, Rehabilitation, and Recovery Plan.
STAFFING	**Clinical Director:** Must have five years of experience in substance use disorder treatment Must be one of the following: • Psychiatrist • Physician • Psychologist • Advanced practice registered nurse (APRN) • Physician Assistant (PA) • Registered Nurse (RN) • Licensed independent mental health practitioner (LIMHP) • Licensed Mental Health Practitioner (LMHP) • Licensed Drug and Alcohol Counselor (LADC) **Licensed Clinicians:** Sufficient to meet staffing ratio **Direct Care staff:** Sufficient to meet staffing ratio **Optional staff may include:** • Community support worker • Certified peer support provider Peer support, community support, and medication management services, if provided by the program, are included in reimbursement and may not be separately reimbursed. All program staff must complete training in overdose prevention and administration of opioid overdose reversal medications. The program must maintain an overdose response protocol Overdose reversal medications must be available at the facility at all times.
STAFFING RATIO	Therapist to individual 1:10

	Direct care staff to individual during day hours 1:10 Awake staff to individual during night hours 1:10 A licensed clinician must be available on-call 24 hours a day
HOURS OF OPERATION	24 hours a day, 7 days a week
CONTINUED STAY REQUIREMENTS	All of the following criteria must be met for continuing treatment at this level of care: • The acuity of the individual's symptoms continues to necessitate treatment at the current level of care based on admission criteria and ASAM guidelines • The individual does not require a more intensive level of services and no less intensive level of care is appropriate • The individual's treatment plan is up to date, with targets that are appropriate and related to improvement in the individual's symptoms and achievement of their goals. • The individual is making progress towards rehabilitation goals and they are showing progress towards symptom reduction as demonstrated by review of ASAM criteria, objective behavioral measurement of functional improvement, or standardized report from the member or guardian of symptom and/or functional improvement. • If progress has not been made or symptoms are increased, the treatment plan has been modified to focus on any new symptoms or to address barriers to progress. • There is evidence that the treatment team is working towards a transition plan to meet the individual's treatment needs once this level of care is no longer appropriate.
DESIRED INDIVIDUAL OUTCOME	• The individual has substantially met the Treatment, Rehabilitation, and Recovery plan goals and objectives • The precipitating condition and relapse potential is stabilized such that there is sustained improvement in health and psychosocial functioning • The individual's condition can be managed without the professional external supports and intervention at this level of care • The individual has alternative support systems secured to help maintain active recovery and stability in the community • The individual is connected to the next appropriate level of care necessary to treat the condition

Adult SUD Co-Occurring Enhanced Residential - ASAM 3.5 (Co-Occurring Enhanced)

Short Term Residential Treatment delivers a safe and stable intensive treatment environment to treat complex biopsychosocial issues, facilitate the recovery process with the development of a supportive recovery network, promote successful involvement in regular productive activity, and prevent the use of substances. This service is highly structured and provides primary, comprehensive substance use disorder treatment. Services align with current edition ASAM level 3.5 guidance

SERVICE CATEGORY	Substance use disorder
SETTING	Adult Substance Use Disorder (SUD) Short Term Residential Substance Use Disorder (Co-Occurring Diagnosis) must be provided in the following setting, in alignment with the current edition, American Society of Addiction Medicine (ASAM) level 3.5: • Facility

BILLING INFORMATION	Fee schedule code for this service is:
	• H0018 HF – Adult Substance Use Disorder Short Term Residential, Co-Occurring Enhanced
	  ○ This code is per diem, not including daily room and board
	Telehealth:
	Services in residential and inpatient programs must be provided in person except as listed below.
	Elements of this service may be provided by telehealth as follows:
	MEDICATION MANAGEMENT
	If the program is not able to identify a psychiatrist or APRN with a specialty certification in addiction medicine who can be present at the facility, medication management may be completed via audiovisual telehealth if all of the following are true:
	  ○ There is a documented formal agreement with a single identified psychiatrist or APRN with a specialty in addiction medicine to provide medication management services for the program

	○ The individual being treated does not have acute psychiatric or medical symptoms that require in-person assessment ○ A physician, APRN, RN, or LPN is physically present with the individual during the medication check to report any physical symptoms that may not be apparent via audiovisual telehealth ○ There is a documented plan in place to provide in-person care in case of an emergency or an acute change in the individual's symptoms **PSYCHOTHERAPY:** Individual, group, and family psychotherapy may be provided via audiovisual telehealth for no more than 10% of psychotherapy services provided for each individual.
ADMISSION REQUIREMENTS	• Age: 21 years of age or older – for youth eligibility, refer to EPSDT requirements as outlined in the definition section of this manual. • The individual demonstrates symptomatology consistent with a substance use disorder diagnosis as outlined in the current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association, which requires and can reasonably be expected to respond to therapeutic intervention • The individual meets applicable dimensional criteria for admission to this service according to the American Society of Addiction Medicine (ASAM), 4th edition criteria Individuals in an ASAM Level 3.5 Dual Diagnosis Capable programs may have co-occurring mental disorders that meet the stability criteria for placement in a Dual Diagnosis Capable program; or difficulties with mood, behavior or cognition related to a substance use or mental disorder; or emotional, behavioral or cognitive symptoms that are troublesome but do not meet current edition DSM criteria for a severe and persistent mental disorder • It is expected that the individual will be able to benefit from this treatment • This level of care is the least restrictive setting that will produce the desired results in accordance with the needs of the individual
SERVICE EXPECTATIONS	**Assessments** • If an IDI was completed within 12 months prior to admission, and is determined to be clinically relevant, it may serve as the admission IDI. If there has been a gap in treatment of six months or more, or if

there is new information available, an IDI addendum must be completed and may serve as the admission IDI.

- If an Initial Diagnostic Interview (IDI) has not been completed within the 12 months prior to admission, a new IDI or IDI addendum must be completed within 24 hours of the beginning of treatment. The IDI must meet the requirements as noted in the Initial Diagnostic Interview definition in this manual

If the licensed clinician completing the IDI cannot diagnose substance use disorders within their professional competencies, a substance use disorder (SUD) assessment must also be completed. If an individual is being treated for a substance use disorder only, an SUD assessment may be completed as a substitute for an IDI:

  - If an SUD assessment was completed within 12 months prior to admission to the service, and is determined to be clinically relevant, it can serve as the SUD assessment. If there has been a gap in treatment of six months or more, or if there is new information available, an SUD addendum must be completed and may serve as the SUD assessment
  - If an SUD assessment has not been completed within the 12 months prior to admission, a new SUD assessment or addendum must be completed within 24 hours of the beginning of treatment and must establish the need for this service. The SUD assessment must meet the requirements outlined in the SUD Assessment definition in this manual

- A History and Physical (H&P) does not meet the requirements of this definition and may not substitute for an SUD assessment.
- A nursing assessment by an RN, or LPN under RN supervision, must be completed within 24 hours of admission with recommendations for further in-depth physical examination as indicated
- A physical examination by a physician or APRN, including a withdrawal management assessment and evaluation for addiction medication needs, must be completed within 72 hours of admission if performed by the program. If the program cannot complete the physical exam, referrals must be completed within 72 hours.

Treatment Planning

- An initial Treatment, Rehabilitation, and Recovery Plan must be developed within 24 hours of admission to guide the first seven days of treatment
- Under clinical supervision, the individualized Treatment, Rehabilitation, and Recovery Plan, including discharge plan and

	relapse prevention must be developed with the individual within seven days of admission • Review and update the individualized Treatment, Rehabilitation, and Recovery Plan every 30 days or more often as clinically indicated. Review must be completed with the individual under the direction of a licensed clinician and must include family, guardians, and other supports as authorized by the individual **Clinical Services** ○ The program must have a formal transfer agreement with a provider of Adult Substance Use Disorder Supervised Withdrawal Services (formerly Social Detox/ASAM 3.2) or emergency medicine facility • • Provide daily clinical services for 35 hours per week. The amount, frequency, and intensity of services must be appropriate to individual needs and level of function as determined by ASAM criteria and assessment. Interventions must be provided in accordance with ASAM guidelines, and must include: ○ Individual, family, and group psychotherapy ○ Psychoeducational groups ○ Medication education • Psychoeducational groups must be provided under the direction of licensed clinicians, and may be provided by licensed clinicians or direct care staff • Medication education must be provided by a registered nurse • Weekly medication management as clinically indicated with a psychiatrist or APRN with a specialty certification in psychiatry • Medication management including prescribing, delivery, administration and monitoring of adherence to medications • Medication dispensing: All medications must be stored in a designated locked storage space and administered by a physician, registered nurse, licensed practical nurse or a medication aid under the direction and monitoring of an RN, PA, APRN, or Physician • Treatment for co-occurring mental health conditions must be provided as clinically indicated consistent with ASAM co-occurring enhanced service standards **Support Services** • Provide access to Medication Assisted Treatment (MAT) as medically appropriate • Consultation, referral, or both for medical, psychological, and psychopharmacology needs

	• Telephone or in-person consultation with a physician or APRN must be available 24 hours a day, 7 days a week
	• Assist the individual with accessing community supports and resources. The program must provide the following assistance as appropriate:
	  ○ Coordinate with community resources on behalf of the individual
	  ○ Assist with healthcare navigation
	  ○ Coordinate with and facilitate access to external providers for individuals who require concurrent treatment
	  ○ Assist individuals with application for and access to benefits and social support services
	  ○ Assist individuals with reintegration into the community by identifying and connecting individuals with off-site vocational and educational resources
	
	Discharge planning
	
	• Discharge planning is an ongoing process that occurs through the duration of service. A documented discharge plan must be completed as part of the individualized Treatment, Rehabilitation, and Recovery Plan
	• A transition plan must be completed prior to discharge. A copy of the transition plan must be given to the individual and to providers at the individual's next level of care, as applicable
	• The program must assist individuals with transition and discharge planning. The program must provide the following assistance as appropriate:
	  ○ Assist individuals with identifying and accessing housing resources
	  ○ Coordinate with community resources on behalf of individuals to facilitate successful reintegration into daily activity such as work, school, or family living as appropriate
	  ○ Provide referrals and coordinate transition to a lower or higher level of care as clinically indicated
	• The program must contact the individual and the provider to which they were referred within 72 hours of discharge to ensure continuity of care. If the individual refuses referral or the program is unable to contact the individual this must be documented.

LENGTH OF SERVICE	Length of service is individualized and based on clinical criteria for admission and continuing stay. The anticipated duration of the service must

	be documented in the individualized Treatment, Rehabilitation, and Recovery Plan
STAFFING	**Medical Director** Must be one of the following: • Physician: addiction specialist physician is preferable • Advanced practice registered nurse (APRN) An addiction specialist physician or APRN consultant must be available, if not in the Medical Director position **Clinical Director:** Must be one of the following: • Psychiatrist • Physician • Physician Assistant (PA) • Psychologist • Advanced Practice Registered Nurse (APRN) • Registered Nurse (RN) • Licensed Independent Mental Health Practitioner (LIMHP) • Licensed Mental Health Practitioner (LMHP) • Licensed Drug and Alcohol Counselor (LADC) **Licensed Clinicians:** Sufficient to meet staffing ratio **Licensed Nursing Staff** *Nursing staff must be sufficient to complete required nursing assessments upon admission. Nursing staff may be part-time or contracted.* • Registered Nurse (RN) • Licensed Practical Nurse (LPN) **Direct Care staff:** Sufficient to meet staffing ratio **Optional staff may include:** • Community support worker • Certified peer support provider Peer support, community support, and medication management services, if provided by the program, are included in reimbursement and may not be separately reimbursed. All program staff must complete training in overdose prevention and administration of opioid overdose reversal medications. The program must maintain an overdose response protocol

	Overdose reversal medications must be available at the facility at all times.
STAFFING RATIO	Therapist to individual 1:8 Direct care staff to individual during day hours 1:8 Awake staff to individual during night hours 1:10 A licensed medical provider and a licensed clinician must be available on-call 24 hours a day
HOURS OF OPERATION	24 hours per day, 7 days a week
CONTINUED STAY REQUIREMENTS	All of the following criteria must be met for continuing treatment at this level of care: • The acuity of the individual's symptoms continues to necessitate treatment at the current level of care based on admission criteria and ASAM guidelines • The individual does not require a more intensive level of services and no less intensive level of care is appropriate • The individual's treatment plan is up to date, with targets that are appropriate and related to improvement in the individual's symptoms and achievement of their goals. • The individual is making progress towards rehabilitation goals and they are showing progress towards symptom reduction as demonstrated by review of ASAM criteria, objective behavioral measurement of functional improvement, or standardized report from the member or guardian of symptom and/or functional improvement. • If progress has not been made or symptoms are increased, the treatment plan has been modified to focus on any new symptoms or to address barriers to progress. • There is evidence that the treatment team is working towards a transition plan to meet the individual's treatment needs once this level of care is no longer appropriate.
DESIRED INDIVIDUAL OUTCOME	• The individual has substantially met the Treatment, Rehabilitation, and Recovery plan goals and objectives • The precipitating condition and relapse potential is stabilized such that there is sustained improvement in health and psychosocial functioning

	• Individual's condition can be managed without the professional external supports and intervention at this level of care • Individual has alternative support systems secured to help maintain active recovery and stability in the community • The individual is connected to the next appropriate level of care necessary to treat the condition

Adult SUD Dual-Disorder Residential Treatment - ASAM 3.5 (Co-Occurring Enhanced)

Dual Disorder Residential Treatment is intended for individuals with a primary substance use disorder and a co-occurring severe mental illness requiring a more intensive treatment environment to treat complex biopsychosocial issues and prevent substance use. This service is highly structured, based on acuity, and provides primary, integrated treatment to further stabilize acute symptoms and engage the individual in a program of maintenance, treatment, rehabilitation and recovery. Services align with current edition ASAM level 3.5 guidance

SERVICE CATEGORY	Substance use disorder
SETTING	• Facility
BILLING INFORMATION	Fee schedule code for this service is: • H0018 HH – Adult Substance Use Disorder Dual Diagnosis Residential **Telehealth:** Services in residential and inpatient programs must be provided in person except as listed below. Elements of this service may be provided by telehealth as follows: **MEDICATION MANAGEMENT** If the program is not able to identify a psychiatrist or APRN with a specialty certification in addiction medicine who can be present at the facility, medication management may be completed via audiovisual telehealth if all of the following are true: ○ There is a documented formal agreement with a single identified psychiatrist or APRN with a specialty in addiction medicine to provide medication management services for the program

	○ The individual being treated does not have acute psychiatric or medical symptoms that require in-person assessment ○ A physician, APRN, RN, or LPN is physically present with the individual during the medication check to report any physical symptoms that may not be apparent via audiovisual telehealth ○ There is a documented plan in place to provide in-person care in case of an emergency or an acute change in the individual's symptoms **PSYCHOTHERAPY:** Individual, group, and family psychotherapy may be provided via audiovisual telehealth for no more than 10% of psychotherapy services provided for each individual.
ADMISSION REQUIREMENTS	• Age: 21 years of age or older – for youth eligibility, refer to EPSDT requirements as outlined in the definition section of this manual. • The individual demonstrates symptomatology consistent with a substance use disorder diagnosis as outlined in the current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association, which requires and can reasonably be expected to respond to therapeutic intervention • The individual meets applicable dimensional criteria for admission to this service according to the American Society of Addiction Medicine (ASAM), 4th edition criteria Individuals in an ASAM Level 3.5 Dual Diagnosis Capable programs may have co-occurring mental disorders that meet the criteria for placement in a Dual Diagnosis Capable program; or difficulties with mood, behavior or cognition related to a substance use or mental disorder; or emotional, behavioral or cognitive symptoms that are troublesome but do not meet current edition DSM criteria for a severe and persistent mental disorder • It is expected that the individual will be able to benefit from this treatment • This level of care is the least restrictive setting that will produce the desired results in accordance with the needs of the individual
SERVICE EXPECTATIONS	**Assessments** • If an IDI was completed within 12 months prior to admission, and is determined to be clinically relevant, it may serve as the admission IDI. If there has been a gap in treatment of six months or more, or if

there is new information available, an IDI addendum must be completed and may serve as the admission IDI

- If an Initial Diagnostic Interview (IDI) has not been completed within the 12 months prior to admission, a new IDI or IDI addendum must be completed within 24 hours of the beginning of treatment. The IDI must meet the requirements as noted in the Initial Diagnostic Interview definition in this manual

  If the licensed clinician completing the IDI cannot diagnose substance use disorders within their professional competencies, a substance use disorder (SUD) assessment must also be completed. If an individual is being treated for a substance use disorder only, an SUD assessment may be completed as a substitute for an IDI:
  - If an SUD assessment was completed within 12 months prior to admission to the service, and is determined to be clinically relevant, it can serve as the SUD assessment. If there has been a gap in treatment of six months or more, or if there is new information available, an SUD addendum must be completed and may serve as the SUD assessment.
  - If an SUD assessment has not been completed within the 12 months prior to admission, a new SUD assessment or addendum must be completed within 24 hours of the beginning of treatment and must establish the need for this service. The SUD assessment must meet the requirements outlined in the SUD Assessment definition in this manual

- A History and Physical (H&P) does not meet the requirements of this definition and may not substitute for an IDI.
- A nursing assessment by an RN, or LPN under RN supervision, must be completed within 24 hours of admission with recommendations for further in-depth physical examination as indicated
- A physical examination by a physician or APRN must be completed within 72 hours of admission if performed by the program. If the program cannot complete the physical exam, referrals must be completed within 72 hours. The exam must include a withdrawal management assessment and evaluation for addiction medication needs

Treatment Planning

- An initial Treatment, Rehabilitation, and Recovery Plan must be developed within 24 hours to guide the first seven days of treatment
- Under clinical supervision, develop an Individualized Treatment, Rehabilitation, and Recovery Plan, including discharge plan and

	relapse prevention, with the individual within seven days of admission
	• Review and update the Individualized Treatment, Rehabilitation, and Recovery Plan every 30 days or more often as clinically indicated. Review must be completed with the individual under the direction of a licensed clinician and must include family, guardians, other supports as authorized by the individual
	
	Clinical Services
	  ○ The program must have a formal transfer agreement with a provider of Adult Substance Use Disorder Withdrawal Management Services (formerly ASAM 3.2) or emergency medicine facility
	• Provide daily clinical services for a minimum of 40 hours per week. The amount, frequency, and intensity of services must be appropriate to individual needs and level of function as determined by ASAM criteria and assessment. Interventions must be provided in accordance with ASAM guidelines, and must include:
	  ○ Individual, family, and group psychotherapy
	  ○ Psychoeducational groups
	  ○ Medication education
	• Psychoeducational groups must be provided under the direction of licensed clinicians, and may be provided by licensed clinicians or direct care staff
	• Medication education must be provided by a physician, APRN, pharmacist, PA, RN, or LPN under RN supervision
	• Weekly medication management as clinically indicated with a psychiatrist or APRN with a specialty certification in psychiatry.
	• Monitoring of medication adherence
	• Medication dispensing: All medications must be stored in a designated locked storage space and administered by a physician, registered nurse, licensed practical nurse or a medication aid under the direction and monitoring of an RN, PA, APRN, or Physician
	• Treatment for co-occurring mental health conditions must be provided as clinically indicated consistent with ASAM co-occurring enhanced service standards
	
	Support Services
	• Provide access to Medication Assisted Treatment (MAT) as medically appropriate

	• Consultation, referral, or both for medical, psychological, and psychopharmacology needs
	• Telephone or in-person consultation with a physician or APRN must be available 24 hours a day, 7 days a week
	• Assist the individual with accessing community supports and resources. The program must provide the following assistance as appropriate:
	  ○ Coordinate with community resources on behalf of the individual
	  ○ Assist with healthcare navigation
	  ○ Coordinate with and facilitate access to external providers for individuals who require concurrent treatment
	  ○ Assist individuals with application for and access to benefits and social support services
	  ○ Assist individuals with reintegration into the community by identifying and connecting individuals with off-site vocational and educational resources
	
	Discharge planning
	• Discharge planning is an ongoing process that occurs through the duration of service. A documented discharge plan must be completed as part of the Individualized Treatment, Rehabilitation, and Recovery Plan
	• A transition plan must be completed prior to discharge. A copy of the transition plan must be given to the individual and to providers at the individual's next level of care, as applicable
	• The program must assist individuals with transition and discharge planning. The program must provide the following assistance as appropriate:
	  ○ Assist individuals with identifying and accessing housing resources
	  ○ Coordinate with community resources on behalf of individuals to facilitate successful reintegration into daily activity such as work, school, or family living as appropriate
	  ○ Provide referrals and coordinate transition to a lower or higher level of care as clinically indicated
	• The program must contact the individual and the provider to which they were referred within 72 hours of discharge to ensure continuity of care. If the individual refuses referral or the program is unable to contact the individual this must be documented.

LENGTH OF SERVICE	Length of service is individualized and based on clinical criteria for admission and continuing stay. The anticipated duration of the service must

	be documented in the Individualized Treatment, Rehabilitation, and Recovery Plan
STAFFING	**Medical Director** Must be one of the following: • Physician: addiction specialist physician is preferable • Advanced practice registered nurse (APRN) A consulting addiction specialist physician or APRN must be available, if not in the Medical Director position **Clinical Director** Must have 5 years of experience in substance use disorder treatment Must be one of the following: • Psychiatrist • Physician • Psychologist • Advanced practice registered nurse (APRN) • Physician Assistant (PA) • Registered Nurse (RN) • Licensed independent mental health practitioner (LIMHP) • Licensed mental health practitioner (LMHP) • Licensed Drug and Alcohol Counselor (LADC) **Licensed Clinicians:** Sufficient to meet staffing ratio **Licensed Nursing staff** • Licensed Registered Nurse (RN) • Licensed Practical Nurse (LPN) **Direct Care staff:** Sufficient to meet staffing ratio **Optional staff may include:** • Community support worker • Certified peer support provider Peer support, community support, and medication management services, if provided by the program, are included in reimbursement and may not be separately reimbursed. All program staff must complete training in overdose prevention and administration of opioid overdose reversal medications. The program must maintain an overdose response protocol

	Overdose reversal medications must be available at the facility at all times.
STAFFING RATIO	Licensed clinician to individual 1:8 Direct care staff to individual during day hours 1:6 Awake staff to individuals during night hours 1:10 A licensed medical provider and a licensed clinician must be available on-call 24 hours a day
HOURS OF OPERATION	24 hours per day, 7 days a week
CONTINUED STAY REQUIREMENTS	All of the following criteria must be met for continuing treatment at this level of care: • The acuity of the individual's symptoms continues to necessitate treatment at the current level of care based on admission criteria and ASAM guidelines • The individual does not require a more intensive level of services and no less intensive level of care is appropriate • The individual's treatment plan is up to date, with targets that are appropriate and related to improvement in the individual's symptoms and achievement of their goals. • The individual is making progress towards rehabilitation goals and they are showing progress towards symptom reduction as demonstrated by review of ASAM criteria, objective behavioral measurement of functional improvement, or standardized report from the member or guardian of symptom and/or functional improvement. • If progress has not been made or symptoms are increased, the treatment plan has been modified to focus on any new symptoms or to address barriers to progress. • There is evidence that the treatment team is working towards a transition plan to meet the individual's treatment needs once this level of care is no longer appropriate.
DESIRED INDIVIDUAL OUTCOME	• The individual has substantially met the Treatment, Rehabilitation, and Recovery Plan goals and objectives • The precipitating condition and relapse potential is stabilized such that there is sustained improvement in health and psychosocial functioning

	• The individual's condition can be managed without the professional external supports and intervention at this level of care • The individual has alternative support systems secured to help maintain active recovery and stability in the community • The individual is connected to the next appropriate level of care necessary to treat the condition

Inpatient Services

Inpatient Psychiatric Hospitalization

Inpatient Hospital Psychiatric Treatment provides acute and sub-acute short term, intensive, recovery-oriented services designed to stabilize an individual who is experiencing a decreased level of functioning due to a mental health condition.

This service provides:

- Stabilization and support
- Engages the individual in comprehensive treatment, rehabilitation, and recovery activities
- Transitions the individual to the least restrictive safe setting as rapidly as possible

ALLOWABLE SETTINGS	Hospital
BILLING INFORMATION	Revenue codes for acute/sub-acute psychiatric: **1. Acute inpatient psychiatric hospitalization:** • Room and Board Private (one bed): 0114 – Psychiatric • Room and Board Semi-private (two beds): 0124 – Psychiatric • Room and Board (3 and 4 beds): 0134 – Psychiatric • Room and Board Deluxe Private: 0144 – Psychiatric • Room and Board Ward: 0154 – Psychiatric • Intensive Care Unit: 0204 – Psychiatric **2. Subacute inpatient psychiatric hospitalization:** • 190 – General Psychiatric

	TELEHEALTH: Services in residential and inpatient programs must be provided in person except as listed below: **MEDICATION MANAGEMENT** If the program is not able to identify a psychiatrist or psychiatric APRN who can be present at the facility, medication management may be completed via audiovisual telehealth if all of the following are true: ○ There is a documented formal agreement with a single identified psychiatrist or psychiatric APRN to provide medication management services for the program ○ The individual being treated does not have acute withdrawal, psychiatric or medical symptoms that require in-person assessment ○ A physician, APRN, RN, or LPN is physically present with the individual during the medication check to report any physical symptoms that may not be apparent via audiovisual telehealth ○ There is a documented plan in place to provide in-person care in case of an emergency or an acute change in the individual's symptoms **PSYCHOTHERAPY:** Individual, group, and family psychotherapy may be provided via audiovisual telehealth for no more than 10% of psychotherapy services provided for each individual.
ADMISSION CRITERIA	• Age: any • The individual demonstrates acute exacerbation of symptomatology consistent with a diagnosis as outlined in the current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association, which requires and can reasonably be expected to respond to therapeutic intervention • There is a clear and reasonable inference of imminent serious harm to self or others as evidenced by having any one of the following: ○ An imminent plan/intent to harm self or others ○ Recent attempts to harm self or others with continued risk due to poor impulse control or an inability to plan reliably for safety ○ Violent, unpredictable or uncontrolled behavior related to the behavioral health disorder that represents an imminent risk of serious harm to self or others, or ○ An imminently dangerous inability to care adequately for their own physical needs or to participate in such care due to disordered, disorganized or bizarre behavior

	• The individual requires an acute psychiatric assessment technique or intervention that unless managed in an inpatient setting could potentially lead to serious imminent and dangerous deterioration of the individual's general medical or mental health • The individual requires 24 hours a day of psychiatric care in a controlled environment that includes medication monitoring and administration, therapeutic intervention, quiet room, restrictive safety measures, and suicidal/homicidal observation and precautions • Due to the risk of psychiatric instability, the need for hospitalization beyond 23 hours with intensive medical and therapeutic intervention is indicated • This level of care is the least restrictive setting that will produce the desired results in accordance with the needs of the individual
SERVICE REQUIREMENTS	**Assessments** • A physical examination, including a complete neurological examination when indicated, must be performed within 24 hours of admission by a licensed physician or APRN • The attending psychiatrist assumes responsibility for the individual at the time of admission and directs treatment based on medical necessity • An advanced practice registered nurse (APRN), registered nurse (RN), or Licensed Practical Nurse (LPN) under RN supervision must complete a Nursing Assessment • Psychiatric nursing care must be available 24 hours a day, 7 days a week • Other licensed clinicians must be available to evaluate the individual at the time of admission based on their presentation of signs and symptoms • Physicians and other consultants must be available to provide emergency, medical, surgical, dental, diagnostic, and treatment services • Laboratory and radiological services must be available • An Initial Diagnostic Interview (IDI) must be completed in person by the attending psychiatrist, if one has not been completed within the previous 12 months of admission to the service, within 24 hours of the initiation of treatment interventions. The IDI must establish the need for this service. The IDI must meet the requirements as noted in the Initial Diagnostic Interview definition in this manual ○ If the IDI was completed within the previous 12 months of admission to the service, a licensed clinician who is able to diagnose and treat major mental illness within their professional competencies, must review the IDI to determine if the diagnosis and treatment, recovery, and rehabilitation plan are still applicable. If there is new information available, including changes in the treatment, recovery, and rehabilitation plan, an update to the IDI must be documented

	in the form of an IDI addendum. The IDI addendum must reflect the individual's current functional status ○ If the attending psychiatrist determines upon examination that the individual has symptoms suggestive enough to warrant a provisional mental health or substance use disorder diagnosis, but is not capable of completing the initial diagnostic interview during the first 24 hours due to significant medical, mental health, or withdrawal symptoms, the IDI may be deferred but must be completed within 48 hours of admission. The reason for deferment must be documented. • A History and Physical (H&P) does not meet the requirements of this definition and may not substitute for an IDI. **Treatment Planning** • An initial treatment plan must be developed within 24 hours of admission to guide the first 7 days of treatment • Under clinical supervision, develop an Individualized Treatment, Rehabilitation, and Recovery Plan, including discharge plan, with the individual within 7 days of admission • Review and update the Individualized Treatment, Rehabilitation, and Recovery Plan every 7 days or more often as clinically indicated. Review must be completed with the individual under the direction of a licensed clinician and must include family, guardians, other supports as authorized by the individual **Clinical Services** • The attending psychiatrist must evaluate the individual face to face at least five times a week or more often, if medically necessary. The evaluation must be documented in the individual's clinical record • The attending psychiatrist or covering psychiatrist must be available, in person or by telephone, to provide assistance and direction to the treatment teams when needed • The attending psychiatrist must have coverage when not available to provide direction and supervision of the direct care of the individual and the treatment program • Consultants for any emergency, medical, psychiatric, psychopharmacology and psychological needs must be available. If these services are not available within the hospital, consultants or a satisfactory arrangement must be established to safely transfer the individual for these services • Mental health or substance use psychotherapy must be available and offered to the individual as appropriate to their diagnosis and symptoms. The amount, frequency, and intensity of services must be appropriate to individual needs and level of function as determined by clinical assessment. Individuals may be excused from psychosocial services if warranted due to severity of symptoms

ACUTE INPATIENT PSYCHIATRIC HOSPITALIZATION programs must offer:

- Individual psychotherapy a minimum of two times a week
- Group psychotherapy a minimum of three times a week
- Family psychotherapy after obtaining the individual's consent, as needed

SUBACUTE INPATIENT PSYCHIATRIC HOSPITALIZATION programs must offer the following:

- Individual psychotherapy
- Group psychotherapy
- Family psychotherapy after obtaining the individual's consent, as needed

- Provide daily clinical services. The amount, frequency, and intensity of services must be appropriate to individual needs and level of function as determined by clinical assessment. Individuals may be excused from clinical services if warranted due to severity of medical, mental health, or withdrawal symptoms
  - **ACUTE INPATIENT PSYCHIATRIC** programs must offer a minimum of 40 hours of clinical services per week. Clinical services must include:
    - Psychotherapy services as outlined above
    - Psychoeducational groups
    - Medication education
  - **SUBACUTE INPATIENT PSYCHIATRIC HOSPITALIZATION** programs must offer a minimum of 20 hours of clinical services per week. Clinical services must include:
    - Psychotherapy services as outlined above
    - Psychoeducational groups
    - Medication education
- Medication education must be provided by a physician, APRN, pharmacist, PA, RN, or LPN under RN supervision

Support Services

- Provide access to Medication Assisted Treatment (MAT) as medically appropriate
- The program must coordinate care with the individual's primary care provider and psychotherapy provider, if applicable
- Consultation, referral, or both for medical, psychological, and psychopharmacology needs
- Case management services 5 days per week to assist the individual with accessing community supports and resources. The program must provide the following assistance as appropriate:
  - Coordinate with community resources on behalf of the

	individual ○ Assist with healthcare navigation ○ Coordinate with the individual's other treating providers ○ Assist individuals with application for and access to benefits and social support services ○ Assist individuals with reintegration into the community by identifying and connecting individuals with off-site vocational, educational, and rehabilitative resources **Discharge Planning** • Discharge planning is an ongoing process that occurs through the duration of service. A documented discharge plan must be completed upon admission as part of the initial treatment, recovery, and rehabilitation plan • A transition plan must be completed prior to discharge. A copy of the transition plan must be given to the individual and to providers at the individual's next level of care, as applicable • The program must assist individuals with transition and discharge planning. The program must provide the following assistance as appropriate: ○ Assist individuals with identifying and accessing housing resources ○ Coordinate with community resources on behalf of individuals to facilitate successful reintegration into daily activity such as work, school, or family living ○ Provide referrals and coordinate transition to the appropriate level of care as clinically indicated • The program must contact the individual and the provider to which they were referred within 72 hours of discharge to ensure continuity of care. If the individual refuses referral or the program is unable to contact the individual this must be documented.
LENGTH OF SERVICE	Length of service is individualized and based on clinical criteria for admission and continuing stay. The anticipated duration of the service must be documented in the Individualized Treatment, Rehabilitation, and Recovery Plan
STAFFING REQUIREMENTS	**Medical Director** Must have 2 years of experience in mental health disorder treatment May be one of the following: • Psychiatrist • Physician • Advanced Practice Registered Nurse (APRN) A consultant psychiatrist must be available, if not in the Medical Director position

	The medical director may serve as the attending provider for each individual depending on the size of the hospital. **Clinical Director** Must be one of the following: • Psychiatrist • Physician • Psychologist • Advanced practice registered nurse (APRN) • Registered Nurse (RN) • Physician Assistant (PA) • Licensed independent mental health practitioner (LIMHP) • Licensed mental health practitioner (LMHP) **Licensed Clinicians:** Sufficient to meet staffing ratio A licensed clinician must be available on call 24 hours a day. **Director of Nursing** Must have education or experience in the treatment of mental health disorders Must be one of the following: • Advanced practice registered nurse (APRN) • Registered nurse (RN) **Licensed Nursing staff** Psychiatric nursing care must be available 24 hours a day, 7 days a week May include: • Licensed Registered Nurse (RN) • Licensed Practical Nurse (LPN) **Social work staff:** May Include: • Master Social Worker • Licensed Clinical Social Worker • Community Support Worker **Direct Care staff:** Sufficient to meet staffing ratio All program staff must complete training in overdose prevention and administration of opioid overdose reversal medications. The program must maintain an overdose response protocol Overdose reversal medications must be available at the facility at all times.

STAFFING RATIO	Licensed clinician to individual 1:8 Direct care staff to individual during day hours 1:10 Minimum of two awake staff during night hours A licensed clinician must be available on-call 24 hours a day
HOURS OF OPERATION	24 hours a day, 7 days a week
CONTINUED STAY REQUIREMENTS	All of the following criteria must be met for continuing treatment at this level of care: • The acuity of the individual's symptoms continues to necessitate treatment at the current level of care based on admission criteria • The individual does not require a more intensive level of services and no less intensive level of care is appropriate • The individual's treatment plan is up to date, with targets that are appropriate and related to improvement in the individual's symptoms and achievement of their goals. • The individual is making progress towards rehabilitation goals and they are showing progress towards symptom reduction as demonstrated by objective behavioral measurement of functional improvement or standardized report from the member or guardian of symptom and/or functional improvement. • If progress has not been made or symptoms are increased, the treatment plan has been modified to focus on any new symptoms or to address barriers to progress. • There is evidence that the treatment team is working towards a transition plan to meet the individual's treatment needs once this level of care is no longer appropriate.
DESIRED INDIVIDUAL OUTCOME	• The individual has substantially met the treatment, recovery, and rehabilitation plan goals and objectives • The precipitating condition and relapse potential is stabilized such that there is sustained improvement in health and psychosocial functioning • The individual's condition can be managed without the professional external supports and intervention at this level of care • The individual has alternative support systems secured to help maintain active recovery and stability in the community • The individual is connected to the next appropriate level of care necessary to treat the condition

Medically Monitored Inpatient Withdrawal (ASAM 3.7)

Medically Monitored Inpatient Withdrawal Management (ASAM Level 3.7-WM) is a non-hospital intervention delivered by medical, nursing, mental health and substance use clinicians, which provide 24-hour medically monitored evaluation under physician-approved policies and procedures or clinical protocols

This level of care is appropriate for individuals with biomedical, emotional, behavioral and/or cognitive conditions that require highly structured services including direct evaluation, observation, and medically monitored addiction treatment. This service is suitable for individuals whose withdrawal signs and symptoms are sufficiently severe to require 24-hour care, but do not require the full resources of an acute care general hospital or a medically managed intensive inpatient program

SERVICE CATEGORY	Substance use disorder
SETTING	Inpatient, non-hospital setting
BILLING INFORMATION	Fee schedule code for this service is: • H0010 ASAM Level 3.7 – Withdrawal Management - Medically Monitored Residential Withdrawal Management (per diem) **Telehealth:** Services in residential and inpatient programs must be provided in person except as listed below. Elements of this service may be provided by telehealth as follows: **MEDICATION MANAGEMENT** If the program is not able to identify a psychiatrist or APRN with a specialty certification in addiction medicine who can be present at the facility, medication management may be completed via audiovisual telehealth if all of the following are true: ○ There is a documented formal agreement with a single identified psychiatrist or APRN with a specialty in addiction medicine to provide medication management services for the program

	○ The individual being treated does not have acute withdrawal, psychiatric or medical symptoms that require in-person assessment ○ A physician, APRN, RN, or LPN is physically present with the individual during the medication check to report any physical symptoms that may not be apparent via audiovisual telehealth ○ There is a documented plan in place to provide in-person care in case of an emergency or an acute change in the individual's symptoms **PSYCHOTHERAPY:** Individual, group, and family psychotherapy may be provided via audiovisual telehealth for no more than 10% of psychotherapy services provided for each individual.
ADMISSION REQUIREMENTS	• Age: 21 years of age or older – for youth eligibility, refer to EPSDT requirements as outlined in the definition section of this manual. • The individual meets the diagnostic criteria for a moderate or severe substance use disorder or their presenting symptoms indicate a preliminary diagnosis for a moderate or severe substance use disorder as outlined in the current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association • The individual meets applicable dimensional criteria for admission to this service according to the American Society of Addiction Medicine (ASAM), 4th edition criteria It is expected that the individual will be able to benefit from this treatment • This level of care is the least restrictive setting that will produce the desired results in accordance with the needs of the individual
SERVICE EXPECTATIONS	**Medical Assessments** • A nursing assessment by an RN, or LPN under RN supervision, must be completed within 24 hours of admission. The assessment must be sufficient to determine the appropriate level of care in which the individual should be placed, and to evaluate whether the individual can be managed safely at this level of care. The evaluation should include recommendations for further in-depth physical examination as indicated • A physical assessment by a physician, physician assistant (PA), or advanced practice registered nurse (APRN) must be completed within 24 hours of admission, or earlier if medically necessary. This assessment must include a withdrawal management assessment and evaluation for addiction medication needs. If a physical exam has been performed within the preceding 7 days at a higher level of care, that exam must be reviewed by the physician

Substance Use and Mental Health Disorder Assessments:

- A substance use focused history must be completed upon admission, or available for a physician to review during the admission process
- A mental status examination must be completed at the time of admission by a licensed clinician
- A Substance Use Disorder (SUD) Assessment must be completed, updated, or reviewed by a licensed clinician within 24 hours of the beginning of treatment. The SUD Assessment must meet the requirements as noted in the SUD Assessment definition in this manual.
    - If the physician, PA, or APRN performing the physical assessment determines upon examination that the individual has symptoms suggestive enough to warrant a provisional substance use disorder diagnosis, but is not capable of completing the substance use disorder assessment during the first 24 hours due to significant medical or withdrawal symptoms, the substance use disorder assessment and history may be deferred but must be completed within 48 hours of admission. The reason for deferment must be documented
    - If a substance use disorder assessment was conducted within the previous 12 months prior to admission to the service, and is determined to be clinically relevant, it can serve as the SUD assessment for this service. If there is new information available, an update to the SUD assessment must be documented in the form of a SUD addendum. The SUD addendum must reflect the individual's current status
- A History and Physical (H&P) does not meet the requirements of this definition and may not substitute for the SUD assessment.

Treatment Planning

- An initial treatment plan must be developed upon admission
- Review and update the initial treatment plan daily. Review must be completed under the supervision of a licensed clinician with the individual
- All efforts to engage the individual in development of the individual's initial treatment plan must be made. If the individual is not capable of participating in treatment plan development due to significant withdrawal symptoms, the reason for their lack of involvement must be documented
- The individual must be assessed daily for progress through withdrawal management and the initial treatment, recovery, and rehabilitation plan

Clinical Services

	• Hourly monitoring by licensed nursing staff
	• Daily on-site care and evaluation by a physician, PA or APRN
	• Medication administration by a physician, APRN, PA, RN, or LPN under RN supervision
	• Medical monitoring of withdrawal and other co-occurring symptoms
	• Daily assessment of progress through withdrawal by a physician, APRN, or registered nurse. Treatment changes are made based on these evaluations
	• A minimum of 3.5 hours of nursing care per individual per day provided by an APRN, RN, or LPNs or CNAs under RN supervision
	• Provide medications to ease the discomfort of withdrawal symptoms
	• A physician or APRN with controlled substance prescribing authority, including buprenorphine, must be available in person or via telehealth 24 hours a day, 7 days a week
	• A physician with professional competencies to manage withdrawal and co-occurring medical conditions must be available in person or via telehealth 24 hours a day, 7 days a week
	
	Substance Use and Mental Health Disorder Services
	• Biopsychosocial screenings as clinically indicated
	• Provide daily clinical services for a minimum of 20 hours per week. The amount, frequency, and intensity of services must be appropriate to individual needs and level of function as determined by ASAM criteria and assessment. Individuals may be excused from psychosocial services if warranted due to medical symptoms or severity of withdrawal symptoms. Interventions must be provided in accordance with ASAM guidelines, and must include:
	  ○ Individual, family, and group psychotherapy
	  ○ Psychoeducational groups
	  ○ Medication education
	• Psychoeducational groups must be provided under the direction of licensed clinicians, and may be provided by licensed clinicians or direct care staff
	• Medication education must be provided by a physician, APRN, pharmacist, PA, RN, or LPN under RN supervision
	• Psychoeducational groups may be provided by a formally contracted provider or program
	
	Support Services
	• Provide access to Medication Assisted Treatment (MAT) as medically appropriate
	• Consultation, referral, or both as needed for medical, psychological, and psychopharmacology needs
	• Assist the individual with accessing community supports and resources. The program must provide the following assistance as appropriate:

	○ Coordinate with community resources on behalf of the individual ○ Assist with healthcare navigation ○ Coordinate with and facilitate access to external providers for individuals who require concurrent treatment ○ Assist individuals with application for and access to benefits and social support services ○ Assist individuals with reintegration into the community by identifying and connecting individuals with off-site vocational and educational resources **Discharge Planning** • Discharge planning is an ongoing process that occurs through the duration of service. • A Transition plan must be completed prior to discharge. A copy of the transition plan must be given to the individual and to providers at the individual's next level of care, as applicable • The program must assist individuals with transition and discharge planning. The program must provide the following assistance as appropriate: ○ Assist individuals with identifying and accessing housing resources ○ Coordinate with community resources on behalf of individuals to facilitate successful reintegration into daily activity such as work, school, or family living as appropriate ○ Provide referrals and coordinate transition to a lower or higher level of care as clinically indicated • The program must contact the individual and the provider to which they were referred within 72 hours of discharge to ensure continuity of care. If the individual refuses referral or the program is unable to contact the individual this must be documented.
LENGTH OF SERVICE	• The individual continues in the Level 3.7-WM program until withdrawal signs and symptoms are sufficiently resolved that they can be safely managed at a less intensive level of care, or • The individual's signs or symptoms of withdrawal have failed to respond to MMIW treatment and have intensified, such that a transfer to a more intensive level of care is indicated
STAFFING	**Medical Director** Must have 3 years of experience in substance use disorder treatment, and be one of the following: • Physician: addiction specialist physician is preferable • Advanced practice registered nurse (APRN)

	A consulting addiction specialist physician or APRN must be available, if not in the Medical Director position **Clinical Director** Must have five years of experience in substance use treatment. Must be one of the following: • Psychiatrist • Physician • Psychologist • Advanced practice registered nurse (APRN) • Registered Nurse (RN) • Physician Assistant (PA) • Licensed independent mental health practitioner (LIMHP) • Licensed mental health practitioner (LMHP) • Licensed Drug and Alcohol Counselor (LADC) **Licensed Clinicians:** Sufficient to meet staffing ratio A licensed clinician must be available on call 24 hours a day, 7 days a week **Licensed Nursing staff** • Licensed Registered Nurse (RN) • Licensed Practical Nurse (LPN) **Medication Dispensing:** Appropriately licensed and credentialed staff must be available to administer medications in accordance with physician orders. **Direct Care staff:** Sufficient to meet staffing ratio If there is not a nurse on site 24/7, direct care staff must hold a current license from the Nebraska Division of Public Health as an emergency medical technician **Additional Requirements** A Physician or APRN must be available 24 hours per day to supervise the clinical practice and medically manage the care of the individual All program staff must complete training in overdose prevention and administration of opioid overdose reversal medications. The program must maintain an overdose response protocol and have a formal relationship with an emergency medicine provider. Overdose reversal medications must be available at the facility at all times.
STAFFING RATIO	Licensed clinicians to individuals during day hours 1:8 Direct care staff to individual during day hours 1:6 Awake staff during night hours 1:10 – must be at least 2 during all night hours

	A licensed clinician must be available on-call 24 hours a day A Physician or APRN must be available 24 hours per day to supervise the clinical practice and medically manage the care of the individual
HOURS OF OPERATION	24 hours a day, 7 days a week
CONTINUED STAY REQUIREMENTS	• The individual continues in MMIW until withdrawal signs and symptoms are sufficiently resolved that they can be safely managed at a less intensive level of care • The acuity of the individual's symptoms continues to necessitate treatment at the current level of care based on admission criteria and ASAM guidelines • The individual does not require a more intensive level of services and no less intensive level of care is appropriate • The individual is making progress towards rehabilitation goals and they are showing progress towards symptom reduction as demonstrated by review of ASAM criteria, objective behavioral measurement of functional improvement, or standardized report from the member or guardian of symptom and/or functional improvement. If progress has not been made or symptoms are increased, the treatment plan has been modified to focus on any new symptoms or to address barriers to progress. • There is evidence that the treatment team is working towards a transition plan to meet the individual's treatment needs once this level of care is no longer appropriate. • Transfer to a more intensive level of care is indicated when the individual's signs and symptoms of withdrawal have failed to respond to treatment and have intensified (as confirmed by higher scores on standardized scoring assessment)
DESIRED INDIVIDUAL OUTCOME	• The individual meets the treatment, recovery, and rehabilitation plan goals and objectives including successful detoxification and stabilization of withdrawal symptoms • The individual is referred to ongoing withdrawal treatment and recovery services • The individual has support systems in place to help the individual maintain stability in the community

General Service Limitations

Non-Covered Services

Services not covered include, but are not limited to:

1. Biofeedback services
2. Treatment that is primarily supportive, social or educational in nature
3. Art, play, or music therapy when provided as the primary modality of treatment

Services must meet the following requirements:

- For rehabilitation services provided at a work site, the rehabilitation service must not be job tasks oriented.
- Any services or components of services which the basic nature is to supplant housekeeping, homemaking, or basic services for the convenience of a person receiving covered services (including housekeeping, shopping, child care, and laundry services) are not covered.
- Services shall not be provided in an Institution for Mental Disease (IMD).
- Room and board is excluded from any services or rates provided in a residential setting.
- Transportation of children is not included in rehabilitation services or rates.
- Education services are not included in or eligible for payment by Nebraska Medicaid, and do not apply toward the hours of minimum treatment activities for any service in this section. Practitioners providing services to youth must be familiar with each youth's IEP and coordinate with the youth and the youth's school to achieve the IEP. Education services may not be the primary reason for rehabilitation admission or treatment. Academic education services, when required by law, must be available.

Specific Service Limitations

Payments to Physicians (MD or DO), Physician Assistants (PAs), and advance practice registered nurses (APRNs) for mental health and substance use disorder services

To provide Nebraska Medicaid covered behavioral health services, Physicians (MD or DO), Physicians Assistants (PAs), and advanced practice registered nurses (APRNs) must be enrolled with a provider group of either a hospital, a clinic (hospital-based clinic, licensed mental health center), or a professional clinic. The provider group must additionally be enrolled under the specialty type of psychiatric/mental health/substance abuse. Physicians (MD or DO), Physicians Assistants (PAs), and advanced practice registered nurses (APRNs) must be enrolled under a mental health specialty for the provider to provide Nebraska Medicaid covered behavioral health services.

When a physician, physician assistant (PA) or advanced practice registered nurse (APRN) provides psychotherapy services, medication management checks are considered a part of the psychotherapy service.

Exceptions:

Providers billing the codes as listed in the table below require a mental health specialty only if the member receiving services has a mental health or substance use diagnosis. Providers eligible to bill these codes are indicated on the Mental Health and Substance Use fee schedule

96130	96136
96131	96137
96132	96138
96133	96139

The codes as listed in the table below may be provided without a mental health specialty. Providers are expected to operate within their professional competencies when providing mental health or substance use services using these codes. Providers eligible to bill these codes are indicated on the Mental Health and Substance Use fee schedule

96372	99205	99222	99242	99255	99310	99349
98966	99211	99223	99243	99304	99341	99350
98967	99212	99231	99244	99305	99342	96372

98968	99213	99232	99245	99306	99344	99492
99202	99214	99233	99252	99307	99345	99493
99203	99215	99238	99253	99308	99347	99494
99204	99221	99239	99254	99309	99348	

Certified Peer Support Services

In order to provider Certified Peer Support services via telehealth, there must be at least one documented in-person visit with the individual being served at least once every 30 days.

Certified Peer Support is an ancillary service and must be provided in conjunction with one or more behavioral health services provided by a licensed clinician. The individual must have at least one clinical encounter (e.g. psychotherapy, medication management) with a licensed clinician for every 60 days of peer support