



United Behavioral Health

Supplemental Clinical Criteria: Nebraska Medicaid

Document Number: BH803NESCC092022

Effective Date: November, 2022

Table of Contents

- [Instructions for Use](#)
- [Applied Behavioral Analysis](#)
- [Assertive Community Treatment](#)
- [Child-Parent Psychotherapy](#)
- [Community Support](#)
- [Community Treatment Aide](#)
- [Crisis Psychotherapy](#)
- [Crisis Stabilization Services](#)
- [Day Rehabilitation](#)
- [Day Treatment Adult](#)
- [Day Treatment Youth](#)
- [Electroconvulsive Therapy](#)
- [Functional Behavioral Assessment](#)
- [Functional Family Therapy](#)
- [Inpatient Treatment](#)
- [Intensive Outpatient Treatment Adult](#)
- [Intensive Outpatient Treatment Youth](#)
- [Multisystemic Therapy](#)
- [Nebraska Therapeutic Community-Family Based Support](#)
- [Observation Room](#)
- [Outpatient Assessment & Treatment](#)
- [Parent-Child Interaction Therapy](#)
- [Partial Hospitalization](#)
- [Peer Support Services](#)
- [Psychiatric Nursing](#)
- [Psychiatric Residential Rehabilitation](#)
- [Psychiatric Residential Treatment Facility](#)
- [Risk Assessment for Youth who Sexually Harm](#)
- [Secure Psychiatric Residential](#)
- [Subacute Inpatient Treatment](#)
- [Therapeutic Group Home](#)

[Testing Guidelines \(Please apply the NE description below and Please see the American Psychological Association Guidelines for Psychological and Neurological Testing\)](#)

[References](#)

[Revision History](#)

INSTRUCTIONS FOR USE

This guideline is used to make coverage determinations as well as to inform discussions about evidence-based practices and discharge planning for behavioral health benefit plans managed by Optum®¹. When deciding coverage, the member's specific benefits must be referenced.

All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member's benefits prior to using this guideline. Other clinical criteria may apply. Optum reserves the right, in its sole discretion, to modify its clinical criteria as necessary using the process described in *Clinical Criteria*.

This guideline is provided for informational purposes. It does not constitute medical advice.

Optum may also use tools developed by third parties that are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Optum may develop clinical criteria or adopt externally-developed clinical criteria that supersede this guideline when required to do so by contract or regulation.

The Nebraska behavioral health service definitions (for service requirements) as outlined in this document, the Nebraska State Plan and Nebraska Administrative Code serve as the primary criteria for making clinical determinations.

State Medicaid Behavioral Health Service Definitions supersede the LOCUS/CALOCUS-CASII/ECSII criteria if there is any discrepancy between the two. There may be variations in some of the questions that are asked during the utilization review process, but there are no substantial differences in the information-taking process or the type of information requested from providers.

APPLIED BEHAVIORAL ANALYSIS

Applied Behavior Analysis (ABA) seeks to identify maladaptive behaviors in order to replace those behaviors with socially acceptable behaviors through the use of counseling modalities and behavioral training which may involve interventions to:

- **Change a member's behavior and emotional state;**
- **Address the function and efficiency of the problematic behavior in the least restrictive manner;**
- **Promote the development of alternative adaptive skills; and**
- **Improve socially significant behaviors.**

1. Admission Criteria

- The member has significant functional impairments as a result of maladaptive behaviors associated with a developmental disability.
AND
- Maladaptive behaviors that negatively impact the member's ability to function successfully in home, community and/or school settings are present.
AND
- Of all reasonable options for available to the member, applied behavioral analysis will reasonably improve the member's behavioral functioning.

2. Continued Service Criteria

- The member's condition continues to meet admission guidelines for this level of care.
AND

¹ Optum is a brand used by United Behavioral Health and its affiliates.

- The member does not require a more intensive level of care, and no less intensive level of care would be appropriate.
AND
 - There is reasonable likelihood of substantial benefit as a result of active continuation in the therapeutic program, as demonstrated by objective behavioral measurements of improvement.
3. Discharge Criteria
- The member has substantially met their treatment plan goals and objectives.
AND
 - The precipitating condition is stabilized such that the member's condition can be managed without professional external supports and interventions.
4. Clinical Best Practices
- Evaluation and Service Planning
 - An initial Diagnostic Interview and a Functional Behavior Assessment has been completed prior to admission.
 - A clinical assessment indicates the member's baseline level of functioning and how the member will benefit from highly structured IBT interventions.
 - The following is completed as part of the ASD evaluation:
 - A structured diagnostic interview such as the Autism Diagnostic Interview-Revised (ADI-R) used to evaluate:
 - Family functioning;
 - Communication skills;
 - Motor skills;
 - Cognitive functioning; and
 - Adaptive functioning.
 - The collection of historical information to include:
 - Autism symptoms to include social relatedness, core ASD symptoms and repetitive or unusual behaviors;
 - Pregnancy, neonatal, and developmental history;
 - Previous ASD screening results, if applicable;
 - Medical history to include seizures, sensory deficits, hearing or visual impairments, or other medical and behavioral conditions;
 - History of observations from multiple sources including family members, teachers, other providers and child-care workers, incorporating the use of standardized tools when possible;
 - History of any developmental regression;
 - History of treatment interventions and response to treatment;
 - History of behavior patterns and functional skills.
 - Direct observations include:
 - The member in multiple settings, being attentive to environmental factors;
 - The member's symptoms specific to the areas of social interaction, communication, play and language;
 - Aggression, self-injury or stereotypic behavior or movement;
 - a. A functional behavior assessment and skill assessment may be needed if the member is displaying self-injurious, or other aggressive behaviors.
 - The use of standardized tools such as:
 - a. Autism Behavior Checklist (ABC);
 - b. Autism Diagnostic Observation Schedule (ADOS-2);
 - c. Autism Diagnostic Interview (ADI);
 - d. Childhood Autism Rating Scale (CARS);
 - e. Checklist for Autism in Toddlers (M-CHAT);
 - f. Communication and Symbolic Behavior Scales Developmental Profile – Infant/Toddler Checklist (CSBS-DP-IT).
 - A differential diagnosis from other medical, neurodevelopmental and behavioral conditions, including the identification of comorbidities is completed.

- Once an ASD diagnosis has been established:
- A functional assessment is used to identify behaviors for reduction, and a skills-based assessment to determine skills to be increased should be completed. Targets include areas such as the following:
 - a. Communication skills;
 - b. Language skills;
 - c. Social interaction skills;
 - d. Self-injurious, violent, destructive or other maladaptive behavior.
- The treatment plan identifies:
 - a. The member's strengths and needs,
 - b. Considers community, family and other supports,
 - c. States measurable goals and interventions based on the member's needs, and
 - d. Identifies a discharge plan.
- The member's treatment plan is reviewed at a minimum every 90 days or more often as determined clinically necessary.
- After review, the treatment plan is updated as clinically indicated and signed by the supervising practitioner and other treatment team members, including the member and/or guardian being served.
- Service Delivery
 - The IBT interventions seek to address all of the following:
 - Mitigate the core features of ASD such as impairment in social reciprocity, deficits in communication, and restricted or repetitive behaviors.
 - Include the member's parents in parent training and the acquisition of skills in behavior modification to promote management of skills within the home.
 - Include psychotherapy for higher functioning members.
 - Target specific deficits related to imitation, attention, motivation, compliance and initiation of interaction, and the specific adaptive behaviors that are to be incrementally taught and positively reinforced.
 - Tie to objective and quantifiable treatment goals that have projected timeframes for completion.
 - Have an appropriate level of frequency and intensity driven by:
 - Changes in the targeted behavior(s);
 - The demonstration and maintenance of management skills by the parents/guardians;
 - Whether specific issues are being treated in a less intensive group format (e.g., social skills groups);
 - The member's ability to participate in IBT given attendance at school, daycare or other treatment settings; and
 - The impact of co-occurring behavioral or medical conditions on skill attainment.
 - Interventions may include:
 - Parent instruction,
 - De-escalation techniques,
 - Behavioral management techniques,
 - Coping skills,
 - Social and life skills development.
 - These services shall not be used in place of a school aide or other similar services not involving the parent.
 - Members are taught socially acceptable behaviors via modeling, prompting, roleplaying and reinforcing of appropriate behaviors.
 - Family/Caregiver training is provided to include acceptable behaviors via modeling, prompting, roleplaying, and reinforcing appropriate behaviors to promote consistency for the member.

- If ABA services are performed by a Board Certified Associate Behavior Analyst (BCaBA) or by a Registered Behavior Technician (RBT), supervision is provided under the direction of a Board Certified Behavior Analyst.
- Supervision includes:
 - Critical oversight of a treatment activity or course of action;
 - Review of the treatment plan and progress notes;
 - Member specific case discussion;
 - Periodic assessments of the member; and
 - Diagnosis, treatment intervention or issue specific discussion.
- Involvement of the supervising practitioner must be reflected in the Initial Diagnostic Interview the treatment plan and the interventions provided.
- After hours crisis assistance must be available
- Discharge Planning
 - Transition and discharge planning must begin at the time of admission, be based on transitioning the member to a different level of care, and address the members ongoing treatment needed to maintain and/or continue normal physical and mental development post discharge.

ASSERTIVE COMMUNITY TREATMENT

ASSERTIVE COMMUNITY TREATMENT The Assertive Community Treatment/Alternative Community Treatment (ACT) Team provides high intensity services, and is available to provide treatment, rehabilitation, and support activities seven days per week, twenty-four hours per day, and 365 days per year.

The team has the capacity to provide multiple contacts each day as dictated by the member's needs. The team provides ongoing continuous care for an extended period of time. Members admitted to the service who demonstrate a continued need for treatment, rehabilitation, or support will not be discharged except by mutual agreement between the member and the team.

1. Admission Criteria

- The member is 21 years or older.
AND
- The member is diagnosed with a persistent mental illness as demonstrated by the presence of a primary diagnosis of a psychotic disorder, major affective disorder, or other major mental illness under the current edition of the Diagnostic and Statistical Manual of Mental Disorders.
AND
- The member has been diagnosed with a persistent mental illness for the last 12 months or is expected to have persistent symptoms of the diagnosis for 12 months or longer that results in a degree of limitation that interferes with the member's ability to function independently in two of three functional areas: Vocational/Education, Social Skills, Activities of Daily Living.
AND
- The member has a pattern of remaining at significant risk or a continuing a pattern of institutionalization or dysfunctional living if mental health services are not provided. This pattern has persisted for one year or longer and is likely to endure for one year or longer.
AND
- Functional deficits are present to the degree, that extensive professional multidisciplinary treatment, rehabilitation, and support interventions with 24 hour capability are required.
AND
- The member has a history of high utilization of psychiatric inpatient and emergency services.
AND
- The member has had less than satisfactory response to previous levels of treatment/rehabilitation interventions.

2. Continued Service Criteria

- a. The member continues to meet admission criteria.
AND
 - b. The member does not require a more intensive level of services and no less intensive level of care is appropriate.
AND
 - c. There is reasonable likelihood of substantial benefits as demonstrated by objective behavioral measurements of improvement in functional areas.
AND
 - d. The member is making progress towards treatment/rehabilitation goals.
3. Discharge Criteria
- a. The member has substantially met the agreed upon treatment plan goals and objectives and is stable in a community setting.
4. Clinical Best Practices
- Evaluation and Service Planning
 - An initial diagnostic interview is completed upon admission if one has not been conducted within the 12 months prior to admission. If an initial diagnostic interview was completed within 12 months prior to admission, a licensed professional reviews and, as necessary, updates the information via an addendum ensuring that the information reflects the member's current status and functioning. The review and update is completed within 30 days of admission.
 - An Initial Member Treatment, Rehabilitation, and Recovery Plan must be developed upon the member's admission to the ACT Team.
 - A Treatment, Rehabilitation, and Recovery plan, developed under clinical guidance with the member, should integrate member strengths, needs and preferences, while, considering community, family and other informal supports important to the person served. It should state measurable, attainable goals and specific interventions that include a crisis/relapse prevention plan, completed within 21 days of the completion of the initial diagnostic interview.
 - The ACT Team must review and revise the member's Member Treatment, Rehabilitation, and Recovery Plan every six months, or whenever there is a change in psychiatric condition and/or level of functioning during the member's course of treatment, or more often as necessary to actively review progress made towards goals.
 - The ACT Team is responsible for engaging the member in active involvement in the development of the treatment/service goals.
 - The ACT Team staff must involve pertinent agencies and members of the member's family and social network in the formulation of Member Treatment, Rehabilitation, and Recovery Plans.
 - Service Delivery
 - The ACT Team must provide the interventions necessary to ensure the member receives treatment for identified psychiatric and/or physical conditions.
 - The ACT Team must provide member, family, and group therapy or counseling to assist the member to gain skills in interpersonal relationships, identify and resolve conflicts, and systematically work on identified member goals. Referrals to appropriate support group services may be appropriate.
 - Medication prescribing, delivery, administration and monitoring.
 - Crisis intervention as required.
 - Rehabilitation services, including symptom management skill development, vocational skill development, and psycho-educational services focused on activities of daily living, social functioning, and community living skills.
 - Supportive interventions which include direct assistance and coordination in obtaining basic necessities such as medical appointments, housing, transportation, and maintaining family/other involvement with the member.
 - The ACT Team will offer opportunities for positive peer role modeling and peer support.
 - Clinical supervision must be provided by the team psychiatrist and/or team leader weekly and may occur during daily team meetings, member treatment,

- rehabilitation and recovery plan meetings, side-by-side and face-to-face supervision sessions and record review.
- The Assertive Community Treatment team provides services such as the following to the member's family with the member's consent:
 - Education about the member's condition and its treatment;
 - Education about the member's strengths;
 - Education about the family's role in the member's treatment;
 - Assistance with resolving conflicts;
 - Interventions aimed at promoting the family's collaboration with the ACT team.
 - On average the member is seen 3 times per week. The Assertive Community Treatment team has the capacity to see the member more frequently. Reasons for more frequent contact include:
 - The member's signs and symptoms have worsened.
 - The member response to a new medication needs to be monitored.
 - The member is experiencing an acute serious life event.
 - The Assertive Community Treatment team psychiatrist assesses the member's signs and symptoms, prescribes appropriate medication, and monitors the member's response to the medication.
 - The Assertive Community Treatment team provides ongoing support and liaison services for members who are hospitalized or incarcerated.
 - The Assertive Community Treatment team reaches out and maintains contact with the member when the member becomes isolated or is admitted to a higher level of care.
 - The Assertive Community Treatment team conducts regularly scheduled planning meetings. The purpose of planning meetings is to:
 - Ensure that staff remain familiar with each member's Assertive Community Treatment plan;
 - Provide an opportunity to assess the member's progress and reformulate the Assertive Community Treatment plan as needed;
 - To problem-solve treatment issues;
 - To obtain input from the member, and incorporate the member into decisions about the Assertive Community Treatment plan.

CHILD-PARENT PSYCHOTHERAPY

CHILD-PARENT PSYCHOTHERAPY An evidence-based treatment provided to children birth to age 5, who have experienced at least one traumatic event (e.g. maltreatment, the sudden or traumatic death of someone close, a serious accident, sexual abuse, exposure to domestic violence) and, as a result, are experiencing behavior, attachment, and/or mental health problems, including post-traumatic stress disorder (PTSD).

The primary goal of CPP is to support and strengthen the relationship between a child and his or her parent (or caregiver) as a vehicle for restoring the child's sense of safety, attachment, and appropriate affect and improving the child's cognitive, behavioral, and social functioning.

1. Admission Criteria

- The member demonstrates symptomatology consistent with a DSM (current edition) diagnosis which requires and can reasonably be expected to respond to therapeutic intervention.
AND
- There are significant symptoms, caused by the behavioral health diagnosis, that negatively impact a child's ability to eat, sleep engage in age appropriate social behavior, and meet developmentally appropriate milestones.
AND
- This service is provided in the least restrictive setting that will produce the desired results in accordance with the needs of the member.
AND
- CPP is supported by evidence that the treatment will improve symptoms and functioning for the member member's behavioral health diagnosis.

- AND
 - There is an expectation that the member has the capacity to make significant progress toward treatment goals to the point that CPP is no longer necessary.
 - AND
 - CPP is required for reasons other than primarily for the convenience of the member or the provider.
 - AND
 - Involvement of the member and his/her family with a therapist for the purpose of changing a behavior health condition focusing on the level of family functioning as a whole and address issues related to the entire family system is the focus of treatment.
 - AND
 - Family therapy is recommended through thorough assessments completed by licensed clinicians as medically necessary to achieve goals/objectives for treatment of a behavior health condition.
2. Continued Service Criteria
- Admission guidelines continue to be met.
 - AND
 - Treatment planning is individualized and appropriate to the family's changing condition, with realistic and specific goals and objectives clearly stated.
 - AND
 - All interventions are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice.
 - AND
 - Progress in relation to specific dysfunction is clearly evident and can be described in objective terms, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address lack of progress are evident.
 - AND
 - Care is rendered in a clinically appropriate manner and focused on the family's behavioral and functional outcomes as described in the discharge plan.
 - AND
 - There is documented active discharge planning.
3. Discharge Criteria
- The family has substantially met their treatment plan goals and objectives.
 - AND
 - Family has support systems secured to help them maintain stability in the community.
4. Clinical Best Practices
- Young children should receive CPP services only after a recent appropriate medical evaluation to rule out conditions of a general medical nature. Treatment Planning: A goal-oriented treatment plan with measurable outcomes, and a specific, realistic discharge plan must be developed with the member (identified patient) and the identified, appropriate family members as part of the initial assessment and outpatient family therapy treatment planning process; the treatment and discharge plan must be evaluated and revised as medically indicated. An Initial Diagnostic Interview must be completed prior to the beginning of treatment. Assessment should be ongoing with treatment and reviewed each session.
 - Service Delivery
 - Services must be treatment focused and not rehabilitative or habilitative in nature.
 - There shall be a reasonable expectation that CPP will improve the child's psychiatric symptoms so that the services will no longer be necessary.
 - Consultation and/or referral for general medical, psychiatric, psychological, and psychopharmacology needs.
 - Provided as family psychotherapy.
 - It is the provider's responsibility to coordinate with other treating professionals as needed
 - The essential components of Child-Parent Psychotherapy (CPP) include:
 - Focus on the parent-child relationship as the primary target of intervention.
 - Focus on safety:
 - Focus on safety issues in the environment as needed;
 - Promote safe behavior;
 - Legitimize feelings while highlighting the need for safe/appropriate behavior;

- Foster appropriate limit setting;
- Help establish appropriate parent-child roles.
- Affect regulation:
- Provide developmental guidance regarding how children regulate affect and emotional reactions;
- Support and label affective experiences;
- Foster parent's ability to respond in helpful, soothing ways when child is upset;
- Foster child's ability to use parent as a secure base;
- Develop/foster strategies for regulating affect.
- Reciprocity in Relationships:
- Highlight parent's and child's love and understanding for each other;
- Support expression of positive and negative feelings for important people;
- Foster ability to understand the other's perspective;
- Talk about ways that parent and child are different and autonomous;
- Develop interventions to change maladaptive patterns of interactions.
- Focus on the traumatic event:
- Help parent acknowledge what child has witnessed and remembered;
- Help parent and child understand each other's reality with regards to the trauma;
- Provide developmental guidance acknowledging response to trauma;
- Make linkages between past experiences and current thoughts, feelings, and behaviors;
- Help parent understand link between her own experiences and current feelings and parenting practices;
- Highlight the difference between past and present circumstances;
- Support parent and child in creating a joint narrative;
- Reinforce behaviors that help parent and child master the trauma and gain a new perspective.
- Continuity of Daily Living:
- Foster prosocial, adaptive behavior;
- Foster efforts to engage in appropriate activities;
- Foster development of a daily predictable routine.
- Reflective supervision
- Discharge Planning
 - Length of treatment is individualized and based on clinical criteria for admission and continued treatment, as well as the member's ability to benefit from treatment.

COMMUNITY SUPPORT

COMMUNITY SUPPORT Community Support services will provide rehabilitative and support services for individuals with a primary serious or persistent mental health diagnosis or when appropriate, substance use disorder issues when that is an identified need for the client. Community Support Workers provide direct rehabilitation and support services to the individual in the community with the intention of supporting the individual to maintain stable community living, and preventing exacerbation of their mental illness, substance use disorder or admission to higher levels of care. Service is not provided during the same service delivery hour of other rehabilitation services.

1. Admission Criteria

- The member is 21 years or older and has been assigned a DSM diagnosis consistent with a Serious and Persistent Mental Illness (i.e. a primary diagnosis of Schizophrenia, major affective disorders, PTSD, OCD or other major mental illness and/or substance abuse disorder in the current edition of DSM).
- AND
- The member's Serious and Persistent Mental Illness and/or substance use disorder has been present for the last 12 months, or is expected to last at least 12 months resulting in a degree of limitation that seriously interferes with the member's ability to function independently and appropriately in (2) of the following (3) functional areas.
 - Vocational/Education:
 - Inability to obtain or maintain employment, or cannot maintain employment without extensive supports; or

- Deterioration or decompensation of the member’s mental illness resulting in the inability to establish or pursue educational goals within a 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 inability to behave in a socially appropriate manner without extensive supports; or
 - Inability to participate in adult activities without extensive supports or limited to special activities established for persons with mental illness; or
 - History of dangerousness to self/others.
 - Activities of Daily Living:
 - Inability to consistently perform the range of practical daily living tasks required for basic adult functioning.
- AND
- Symptoms and functional deficits are related to the primary diagnosis.
- AND
- There is an expectation that the member will benefit from rehabilitation services until services are no longer medically necessary.
- AND
- The member’s rehabilitation needs are best met by 1:1 direction with a paraprofessional.
2. Continued Service Criteria
- All of the following are necessary for continuing treatment at this level of care:
 - The member continues to meet admission criteria.
 - The member does not require a more intensive level of care and no other less intensive level of care is appropriate.
 - There is reasonable likelihood of substantial benefit to the member as demonstrated by objective behavioral measurements of improvement in functional areas.
 - The member is making progress toward rehabilitation goals.
3. Discharge Criteria
- The member has met his/her treatment plan goals and objectives.
- AND
- The precipitating condition and relapse potential is stabilized such that member’s condition can be managed without/or with decreased professional external supports and interventions.
- AND
- The member has alternative support systems secured to help him/her maintain stability in the community.
4. Clinical Best Practices
- Evaluation and Planning
 - There has been a complete Initial Diagnostic Interview, no more than 12 months prior to admission to Community Support, to ensure that the member meets the Severe and Persistent Mental Illness criteria.
 - The Initial Diagnostic Interview must identify the need for Community Support and outline the needed services and resources for the member. The IDI shall serve as the treatment plan until the comprehensive plan of care is developed.
 - If the IDI was completed within 12 months prior to admission, a licensed professional should review and update as necessary via an addendum to ensure the information is reflective of the individual’s current status and functioning. The review and update should be completed within 30 days of admit.
 - 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 member, should be completed within 30

- days of admission and may be completed by either non-licensed or licensed members on the member's team.
 - There are Treatment, Rehabilitation, and Recovery Plans for the member. The Treatment, Rehabilitation, and Recovery Plans shall be completed within 30 days following admission and reviewed and updated every 90 days or as often as clinically necessary thereafter.
- Service Delivery
 - Services actively deliver rehabilitation and support interventions with focus on activities of daily living, psychoeducation, budgeting, medication adherence and self-administration (as appropriate and part of the overall treatment/recovery plan), relapse prevention, social skills, and other independent living skills that enable the member to reside in their community.
 - Provide service coordination and case management activities, including coordination or assistance in accessing medical, psychiatric, psychological, social, education, housing, transportation or other appropriate treatment/support services as well as linkage to other community services identified in the treatment/rehabilitation/recovery plan.
 - Assist the member with all health insurance issues including Share of Cost eligibility issues. Ensures member understanding of financial benefits and procedures to use those benefits such as Medicaid spend downs, AABD, SSI and SSA, etc.
 - Develop and implement strategies to encourage the member to become engaged and remain engaged in necessary mental health treatment services as recommended and included in the treatment/rehabilitation/recovery plan.
 - Participate with and report to treatment/rehabilitation team on the member's progress and response to community support intervention in the areas of relapse prevention, substance use/abuse, application of education and skills, and the recovery environment (areas identified in the plan).
 - Provide therapeutic support and intervention to the member in time of crisis and work with the member to develop a crisis relapse prevention plan.
 - Provide contact as needed with other service provider(s), member family member(s), and/or other significant people in the member's life to facilitate communication necessary to support the member in maintaining community living.
 - If hospitalization or residential care is necessary, facilitate, in cooperation with the treatment provider, the member's transition back into the community upon discharge.
- Discharge Planning
 - Length of service is individualized and based on clinical criteria for admission and continued stay, as well as the client's ability to make progress on individual treatment/recovery goals.

COMMUNITY TREATMENT AIDE

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

Services are provided in the member's natural environment is primarily the individual's home but may also include a foster home, school or other appropriate community locations conducive for the delivery of CTA services.

1. Admission Criteria

- There is an established DSM (current edition) diagnosis which requires and will respond to therapeutic intervention.
AND
- There is the presence of psychological symptoms that require this level of care.
AND
- The member is enrolled in active outpatient treatment with a licensed therapist.

- AND
 - The member would require a more restrictive treatment environment without the services of a CTA.
 - AND
 - The member is medically stable and does not require the 24-hour medical/nursing monitoring or procedures provided in a hospital level of care.
 - AND
 - The member must have sufficient medical need for active psychiatric treatment at the time of admission to justify the expenditure of the members and program's time, energy, and resources.
 - AND
 - Of all reasonable options for active psychiatric treatment available to the member, treatment in this program must be the best choice for expecting a reasonable improvement in the member's psychiatric condition.
 - AND
 - The Initial Diagnostic Evaluation must identify the need for this level of care for the member.
2. Continued Service Criteria
- The member's condition continues to meet admission criteria for this level of care.
 - AND
 - The member does not require a more intensive level of care, and no less intensive level of care would be appropriate.
 - AND
 - There is reasonable likelihood of substantial benefit as a result of active continuation in the therapeutic program, as demonstrated by objective behavioral measurements of improvement.
 - AND
 - The member is making progress toward goals and is actively participating in the interventions.
3. Discharge Criteria
- The member has met their treatment plan goals and objectives.
 - AND
 - The precipitating condition and relapse potential is stabilized such that member's condition can be managed without professional external supports and interventions.
 - AND
 - The member has alternative support systems secured to help him/her maintain stability in the community.
4. Clinical Best Practices
- Evaluation and Service Planning
 - An Initial Diagnostic Interview must be completed prior to the beginning of treatment and will serve as the initial treatment plan until the comprehensive plan of care is developed.
 - The member's CTA plan shall be a part of the comprehensive treatment plan developed by the member's outpatient psychotherapy provider and be developed in close collaboration with the therapy provider.
 - The CTA treatment plan must be reviewed and updated every 90 days or sooner as medically necessary and demonstrate collaboration with the outpatient therapist.
 - Service Delivery
 - Outpatient services shall be provided by licensed practitioners whose scope of practice includes mental health and/or substance use disorder services.
 - Treatment interventions should be based on the comprehensive assessment and focused on specific treatment goals inclusive of the culture, expectations and needs as identified by the member and parent/caregiver.
 - The CTA staff is expected to provide interventions which may include: parent instruction, de-escalation techniques, behavioral management techniques, coping skills, and social and life skills development.
 - CTA services shall not be used in place of a school aide or other similar services not involving the parent.

- CTA services shall be delivered under the direction and supervision of the therapist providing family and/or individual therapy.
- The Supervising Practitioner must provide monthly supervision and direction to the CTA therapist. This contact may be by telephone and must be documented in the member's treatment record.
- The parent/caregiver is fully engaged during all CTA services.
- Clinical Direction by a licensed professional (Psychiatrist, APRN, RN, LMHP, PLMHP, LIMHP, Licensed Psychologist, Provisionally Licensed Psychologist); working with the program to provide clinical direction, consultation and support to community support staff and the individuals they serve.
 - The Clinical Supervisor will review individual clinical needs every 30 days. The review should be completed preferably face to face but phone review will be accepted. The review may be accomplished by the supervisor consulting with the worker on the list of assigned individuals and identifying any clinical recommendations in serving the individual.
- Discharge Planning
 - Length of service is individualized and based on clinical criteria for admission and continuing stay, as well as the member's ability to make progress on individual treatment/recovery goals.

CRISIS PSYCHOTHERAPY

CRISIS PSYCHOTHERAPY Crisis outpatient individual or family therapy is an immediate, short-term treatment service provided to an individual. Crisis Psychotherapy is rendered in a professional office, clinic, home or other appropriate environment appropriate to the provision of psychotherapy service.

1. Admission Criteria
 - The member demonstrates symptomatology consistent with a DSM (current edition) diagnosis which requires and can reasonably be expected to respond to therapeutic intervention.
AND
 - Presenting behavioral, psychological, and/or biological dysfunction and functional impairment are consistent and associated with the DSM (current edition) and/or reports a precipitating event.
2. Discharge Criteria
 - The individual is able to remain stable in the community without this treatment.
AND
 - The individual will receive services to address safety and crisis resolution.
3. Clinical Best Practices
 - Evaluation & Treatment Planning
 - Psychotherapy is limited to 2 sessions.
 - If services are to continue, the provider shall complete an IDI and develop a treatment plan if one has not already been completed.
 - Includes active family involvement unless contraindicated.
 - Services must be trauma informed and sensitive to potential personal safety risks such as suicidal intention.
 - The therapist/provider must coordinate care with the individual's primary medical provider and the therapy provider if on-going therapy is authorized.
 - The intervention/safety plan identifies the crisis with steps for further resolution, outlines an individualized safety plan for the individual and/or family, and identifies additional formal and informal supports. The clinician will assist in making appropriate referrals.

CRISIS STABILIZATION SERVICES

CRISIS STABILIZATION SERVICES Crisis Stabilization is intended to provide immediate, short-term, individualized, crisis-oriented treatment and recovery needed to stabilize acute symptoms of mental illness, alcohol and/or other drug use, and/or emotional distress.

Members in need exhibit a psychiatric and/or substance use disorder crisis with a moderate to high risk for harm to self/others and need short-term, protected, supervised, residential placement. The intent of the service is to treat and support the member throughout the crisis; provide crisis assessment and interventions; medication management; linkages to needed behavioral health services; and assist in transition back to the member's typical living situation.

1. Admission Criteria

- The member demonstrates a significant incapacitating or debilitating disturbance in mood/thought interfering with ADLs to the extent that immediate stabilization is required
AND
- The member demonstrates active symptomatology consistent with a DSM (current version) diagnosis which requires and can reasonably be expected to respond to intensive, structured intervention
AND
- A clinical evaluation of the member's condition indicates dramatic and sudden decompensation with a strong potential for danger (but not imminently dangerous) to self or others and member has no available supports to provide continuous monitoring
AND
- The member requires 24 hour observation and supervision but not the constant observation of an inpatient psychiatric setting
AND
- A clinical evaluation indicates that the member can be effectively treated with short-term intensive crisis intervention services and returned to a less intensive level of care within a brief time frame; and
AND
- A less intensive or restrictive level of care has been considered/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.

2. Continued Service Criteria

- The member's condition continues to meet admission guidelines at this level of care.
AND
- The member's treatment does not require a more intensive level of care, and no less intensive level of care would be appropriate.
AND
- Care is rendered in a clinically appropriate manner and focused on member's behavioral and functional outcomes as described in the discharge plan.
AND
- Treatment planning is individualized and appropriate to the member's changing condition with realistic and specific goals and objectives stated.
AND
- All services and treatment are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice.
AND
- Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms, but goals of treatment have not yet been achieved or adjustments in the treatment plan to address lack of progress are evident.
AND
- When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated.
AND
- There is documented active discharge planning.

3. Discharge Criteria

- Symptoms are stabilized and the member no longer meets clinical criteria for crisis stabilization.
AND

- The precipitating condition and relapse potential is stabilized such that member's condition can be managed with professional external supports and interventions outside of the crisis stabilization facility.
4. Clinical Best Practices
- Evaluation & Treatment Planning Crisis Stabilization
 - Multidisciplinary/bio-psychosocial assessments, including a history and physical, and substance use are completed within 24 hours of admission.
 - Assessments and treatment must integrate strengths and needs in both MH/SUD domains.
 - A crisis stabilization plan, which includes relapse/crisis prevention and discharge plan components (consider community, family and other supports), is developed within 24 hours of admission and adjusted daily or as indicated.
 - Service Delivery Crisis Stabilization
 - Interdisciplinary treatment team meetings occur daily or as often as medically necessary including the member, family, and other supports as appropriate.
 - Psychiatric nursing interventions are available to patients 24/7.
 - Medication management is available.
 - Member, group, and family therapy is available and offered as tolerated and/or appropriate using a brief therapy/solution focused approach.
 - Addictions treatment is initiated and integrated into the treatment/recovery plan for co-occurring disorders identified in initial assessment process as appropriate.
 - Intense discharge planning begins at the time of admission.
 - Evaluation & Treatment Planning Crisis Assessment
 - A culturally sensitive assessment is completed by appropriately licensed behavioral health professional that includes at a minimum:
 - Behavioral health diagnosis, risk of dangerousness to self and/or others, and recommended behavioral health services.

DAY REHABILITATION

DAY REHABILITATION Day Rehabilitation services are designed to provide individualized treatment and recovery, inclusive of psychiatric rehabilitation and support for members with a severe and persistent mental illness and/or co-occurring disorders who are in need of a program operating variable hours.

The intent of the service is to support the member in the recovery process so that he/she can be successful in a community living setting of his/her choice.

Day Rehabilitation operates during regularly scheduled days, evenings, or weekend hours with 24/7 on call access to a mental health provider.

1. Admission Criteria

- The member's Serious and Persistent Mental Illness and/or substance use disorder has been present for the last 12 months, or is expected to last at least 12 months resulting in a degree of limitation that seriously interferes with the member's ability to function independently and appropriately in (2) of the following (3) functional areas.
 - Vocational/Education:
 - Inability to obtain or maintain employment, or cannot maintain employment without extensive supports; or
 - Deterioration or decompensation of the member's mental illness resulting in the inability to establish or pursue educational goals within a 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 inability to behave in a socially appropriate manner without extensive supports; or

- Inability to participate in adult activities without extensive supports or limited to special activities established for persons with mental illness; or
 - History of dangerousness to self/others.
 - Activities of Daily Living:
 - Inability to consistently perform the range of practical daily living tasks required for basic adult functioning such as:
 - 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.
- AND
- Functional deficits of such intensity that require daily rehabilitative interventions three to five days a week and three to six hours per day in a structured day setting.
- AND
- The member 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 identified in the above bullet.
- AND
- Symptoms and functional deficits are related to the primary diagnosis.
- AND
- There is an expectation that the member will benefit from rehabilitation services until services are no longer medically necessaryⁱ.
2. Continued Service Criteria
- All of the following are necessary for continuing treatment at this level of care:
 - The member continues to meet admission criteria.
 - The member does not require a more intensive level of care and no other less intensive level of care is appropriate.
 - There is reasonable likelihood of substantial benefit to the member as demonstrated by objective behavioral measurements of improvement in functional areas.
 - The member is making progress toward rehabilitation goals.
3. Discharge Criteria
- The member has met his/her treatment plan goals and objectives.
- AND
- The member has met their treatment/recovery/rehabilitation plan goals and objectives
- AND
- The member has achieved a level of functioning that does not require ongoing, intensive professional external supports and interventions.
- AND
- The member has formal and informal support systems secured to maintain stability in a less restrictive environment.
4. Clinical Best Practices
- Evaluation and Service Planning
 - There has been a complete Initial Diagnostic Interview, no more than 12 months prior to admission to Day Rehabilitation, to ensure that the member meets the Severe and Persistent Mental Illness criteria.
 - If the diagnostic interview was completed within 12 months prior to admission, a licensed professional should review and update as necessary via an addendum, to ensure information is reflective of the member's current status and functioning.
 - The review and update should be completed within 30 days of admission.
 - 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 member, should be completed within 30

- days of admission and may be completed by non-licensed or licensed members on the member's team.
- An initial treatment/rehabilitation/recovery plan to guide the first 30 days of treatment developed within 72 hours of admission.
- Alcohol and drug screening; assessment as needed.
- A treatment/rehabilitation/recovery plan developed with the member, integrating member strengths & needs, considering community, family and other supports, stating measurable goals, that includes a documented discharge and relapse prevention plan completed within 30 days of admission
- Review the treatment/rehabilitation/recovery and discharge plan with treatment team, including the member, every 90 days, making necessary changes then, or as often as medically indicated. Each review should be signed by members of the treatment team, at a minimum the Clinical Supervisor, assigned therapist and member/family/legally responsible person.
- Service Delivery
 - Therapeutic milieu providing active treatment/recovery/rehabilitation activities led by members trained in the provision of recovery principles.
 - The on-site capacity to provide medication administration and/or self-administration, symptom management, nutritional support, social, vocational, and life-skills building activities, self-advocacy, peer support services, recreational activities, and other independent living skills that enable the member to reside in their community.
 - Ability to coordinate other services the member may be receiving and refer to other necessary services.
 - Referral for services and supports to enhance independence in the community.
- Discharge Planning
 - Length of service is individualized and based on clinical criteria for admission and continued stay, as well as the member's ability to make progress on member treatment/recovery goals.

DAY TREATMENT ADULT

DAY TREATMENT ADULTS Psychiatric and substance use day treatment is a service in a continuum of care designed to prevent hospitalization or to facilitate the movement of the acute psychiatric member to a status in which the member is capable of functioning within the community with less frequent contact with the psychiatric health care provider.

1. Admission Criteria

- Adults:
 - The member demonstrates symptomatology consistent with a DSM (current edition) diagnosis which requires and can reasonably be expected to respond to therapeutic intervention.
AND
 - There is an expectation that the member has the capacity to make progress toward treatment goals to where services are no longer necessary.
AND
 - The member is unable to functioning outside the treatment program due to a mental health disorder as evidenced by the following:
 - Psychiatric symptoms requiring medical stabilization.
 - Inability to function in one of the following areas: social, occupational, vocational, educational or an absence of social support resources.
 - Inability to perform activities of daily living (hygiene, self-care, meal preparation and nutrition), interpersonal and leisure skills.
 - AND
 - The frequency, intensity and duration of contact provided in a day program is necessary as evidenced by:
 - Failure to improve/ stabilize with less intensive treatment.
 - The member is at risk of adverse consequences if treatment is not provided.
 - The member requires assistance to manage/monitor their medical, mental health and/or substance use needs.

- The member cannot be safely maintained/effectively treated at a lower level of care.
 - A higher level of care is not necessary.
2. Continued Service Criteria
- The member's condition continues to meet admission guidelines for this level of care.
AND
 - The member does not require a more intensive level of care, and no less intensive level of care would be appropriate.
AND
 - There is reasonable likelihood of substantial benefit as a result of active continuation in the therapeutic program, as demonstrated by objective behavioral measurements of improvement.
AND
 - The member is making progress toward goals and is actively participating in the interventions.
3. Discharge Criteria
- The member has met his/her treatment plan goals and objectives.
AND
 - The precipitating condition and relapse potential is stabilized such that member's condition can be managed without professional external supports and interventions
AND
 - Member has support systems to maintain stability in a less restrictive environment
4. Clinical Best Practices
- Evaluation and Service Planning
 - An initial Diagnostic Interview must be completed prior to admission and functions as the initial treatment plan until a comprehensive treatment plan is developed.
 - The family is provided with opportunities to participate in all aspects of the member's treatment (assessment, treatment planning, therapy and discharge planning) if appropriate. This participation or lack of participation must be documented in the member record.
 - Complete a treatment plan within 10 business days of admission.
 - The treatment plan must be individualized to the member and must include the specific problems, behaviors, or skills to be addressed; clear and realistic goals and objectives; services, strategies, and methods of intervention to be implemented; criteria for achievement; target dates; methods for evaluating the member's progress; and the responsible professional.
 - The member treatment plan is reviewed at least every 30 days and more often as necessary, updated as medically indicated and signed by the supervising practitioner and other treatment team members, including the member being served.
 - Assessments and treatment should address mental health/substance use needs and emotional issues related to medical conditions.
 - Service Delivery
 - Services must be community based, family centered, culturally competent and developmentally appropriate.
 - Provide a flexible meeting schedule to include evenings and weekends.
 - Provide the following mandatory services:
 - Psychological diagnostic services that contribute to the diagnosis and plan of care for the member.
 - One hour of psychotherapy and substance use counseling services, per scheduled treatment day, that demonstrate the member is receiving active treatment for their psychiatric condition. These services may include: Member psychotherapy, group psychotherapy, and family psychotherapy if appropriate.
 - Pharmaceutical services must be provided under the supervision of a registered pharmacy consultant or through a contract agreement with a licensed certified facility.

- Dietary services must be provided and/or contracted with a registered dietitian when meals are provided by a day treatment program.
- Nursing services: a registered nurse will evaluate and provide for the care and treatment of the members medical nursing needs when medically indicated. In a hospital-based day treatment setting, a nursing medical assessment must be completed within 24 hours of admission or the first business day.
- Clinically appropriate assessments, as determined necessary, to assess the member for substance use disorders, eating disorders, or other specialized treatment needs.
- Provide either half-day (3 hours a day, 5 days a week), or full-day (6 hours a day, 5 days a week).
- The program shall identify an on-call system of licensed practitioners available for crisis management when the member is not in the program's scheduled hours and/or the program is not in session.
- Transition and discharge planning must begin at admission, be based on transitioning the member to a different level of care, and address the members ongoing treatment needs.
- Provide at least 2 of the following optional services. The member must have a need for the services, a supervising practitioner must order the services, and the services must be a part of the member's treatment plan:
 - The following must be provided or supervised by a licensed or certified therapist: Recreational therapy; Speech therapy; Occupational therapy; Vocational Skills therapy; and Self-Care Services;
 - Social work provided by a bachelor level social worker (case management activities);
 - Social Skills building; and/or
 - Life Survival skills
 - Provide either half day (3 hours a day, 5 days a week) or full day (6 hours a day, 5 days a week)
- Supervising practitioners (physician or PhD) must be onsite a sufficient amount of time to provide for the psychiatric/clinical care of the patients.
- Psychotherapy and substance abuse counseling services must be provided by clinical staff who is operating within their scope of practice and under the direction of the supervising practitioner.
- Discharge Planning
 - Length of service is individualized and based on clinical criteria for admission and continuing stay, but considering its time-limited expectations, a period of 21-90 days with decreasing days in attendance is typical.

DAY TREATMENT YOUTH

DAY TREATMENT YOUTH Psychiatric and substance use day treatment is a service in a continuum of care designed to prevent hospitalization or to facilitate the movement of the acute psychiatric member to a status in which the member is capable of functioning within the community with less frequent contact with the psychiatric health care provider.

1. Admission Criteria

- The member demonstrates symptomatology consistent with a DSM (current edition) diagnosis which requires and can reasonably be expected to respond to therapeutic intervention.
AND
- Exacerbation or persistence of a long-standing psychiatric disorder results in symptoms of thought, mood, behavior, or perception that significantly impair functioning.
AND
- The member requires assistance to master age appropriate personal and interpersonal life skills (i.e. problem solving, assertiveness, self-advocacy, shopping, meal preparation, development of leisure skills, and the use of community resources).

- AND
 - The member is medically stable and does not require a higher level of care.
 - AND
 - The member is determined to need outpatient level of care providing three to five hours of care up to five times a week.
 - AND
 - The member can reasonably be expected to benefit from mental health/substance use disorder treatment at this level and needs structure for activities of daily living.
- 2. Continued Service Criteria
 - All of the following guidelines are necessary for continuing treatment at this level of care:
 - The member's condition continues to meet admission guidelines for this level of care.
 - The member does not require a more intensive level of care, and no less intensive level of care would be appropriate.
 - There is reasonable likelihood of substantial benefit as a result of active continuation in the therapeutic program, as demonstrated by objective behavioral measurements of improvement.
 - The member is making progress toward goals and is actively participating in the interventions.
- 3. Discharge Criteria
 - The member has met his/her treatment plan goals and objectives.
 - AND
 - The precipitating condition and relapse potential is stabilized such that member's condition can be managed without professional external supports and interventions
 - AND
 - Member has support systems to maintain stability in a less restrictive environment
- 4. Clinical Best Practices
 - Evaluation and Service Planning
 - An initial Diagnostic Interview must be completed prior to admission and functions as the initial treatment plan until a comprehensive treatment plan is developed.
 - The family is provided with opportunities to participate in all aspects of the member's treatment (assessment, treatment planning, therapy and discharge planning) if appropriate. This participation or lack of participation must be documented in the member record.
 - Complete a treatment plan within 10 business days of admission.
 - The treatment plan must be individualized to the member and must include the specific problems, behaviors, or skills to be addressed; clear and realistic goals and objectives; services, strategies, and methods of intervention to be implemented; criteria for achievement; target dates; methods for evaluating the member's progress; and the responsible professional.
 - The member treatment plan is reviewed at least every 30 days and more often as necessary, updated as medically indicated and signed by the supervising practitioner and other treatment team members, including the member being served.
 - Assessments and treatment should address mental health/substance use needs and emotional issues related to medical conditions.
 - Service Delivery
 - Services must be community based, family centered, culturally competent and developmentally appropriate.
 - For youth, services must involve the family in assessment, treatment planning, updating of the treatment plan, therapy and transition/discharge planning. Family involvement, or lack thereof, shall be documented in the clinical record
 - Provide a flexible meeting schedule to include evenings and weekends.
 - Provide the following mandatory services:
 - Psychological diagnostic services that contribute to the diagnosis and plan of care for the member.

- One hour of psychotherapy and substance use counseling services, per scheduled treatment day, that demonstrate the member is receiving active treatment for their psychiatric condition. These services may include: Member psychotherapy, group psychotherapy, and family psychotherapy if appropriate.
 - Pharmaceutical services must be provided under the supervision of a registered pharmacy consultant or through a contract agreement with a licensed certified facility.
 - Dietary services must be provided and/or contracted with a registered dietitian when meals are provided by a day treatment program.
 - Nursing services. Medical services provided by a qualified Registered Nurse who evaluates the medical nursing needs of each individual and provides for their medical care and treatment. In a hospital-based day treatment setting, a nursing medical assessment must be completed within 24 hours of admission or the first business day.
 - Clinically appropriate assessments, as determined necessary, to assess the member for substance use disorders, eating disorders, sex offender behavior or other specialized treatment needs.
 - Medication management must be available to all members participating in a Day Treatment service when medication is prescribed by an appropriately licensed practitioner. This service shall be medically and clinically necessary for the mental health and/or substance use disorder requiring treatment. The practitioner prescribing the medication, whether within the program or outside of the program, shall consult with the program periodically and may bill for all directly delivered medication management services separate from the payment to the program for Day Treatment services.
 - Special treatment procedures: If a child/adolescent needs behavior management and containment beyond unlocked time outs or redirection, special treatment procedures may be utilized. Special treatment procedures in day treatment are limited to physical restraint, and locked time out (LTO). Parents or legal guardian or the Department case manager must approve use of these procedures through informed consent and must be informed within 24 hours each time they are used. Facilities must meet the following standards regarding special treatment procedures:
 - a. De-escalation techniques must be taught to staff and used appropriately before the initiation of special treatment procedures;
 - b. Special treatment procedures may be used only when a child/adolescent's behavior presents a danger to self or others, or to prevent serious disruption to the therapeutic environment; and
 - c. The child/adolescent's treatment plan must address the use of special treatment procedures and have a clear plan to decrease the behavior requiring LTO, or physical restraints.
- Provide a minimum of 3 hours a day, 5 days a week.
 - The program shall identify an on-call system of licensed practitioners available for crisis management when the member is not in the program's scheduled hours and/or the program is not in session.
 - Transition and discharge planning must begin at admission, be based on transitioning the member to a different level of care, and address the members ongoing treatment needs.
 - Provide at least 2 of the following optional services. The member must have a need for the services, a supervising practitioner must order the services, and the services must be a part of the member's treatment plan:

The following must be provided or supervised by a licensed or certified therapist: Recreational therapy; Speech therapy; Occupational therapy; Vocational Skills therapy; and Self-Care Services;

- Social work provided by a bachelor level social worker (case management activities);
- Social Skills building; and/or
- Life Survival skills
- Provide either half day (3 hours a day, 5 days a week) or full day (6 hours a day, 5 days a week)
- Supervising practitioners (physician or PhD) must be onsite a sufficient amount of time to provide for the psychiatric/clinical care of the patients. The supervising practitioner's involvement must be reflected in the member record.
- Psychotherapy and substance abuse counseling services must be provided by clinical staff who is operating within their scope of practice and under the direction of the supervising practitioner.
- Discharge Planning
 - Length of service is individualized and based on clinical criteria for admission and continuing stay.

ELECTROCONVULSIVE THERAPY

ELECTROCONVULSIVE THERAPY ECT is a treatment where an electric current, which is medically controlled, is applied to either or both sides of the brain (unilaterally vs. bilaterally) 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.

1. Admission Criteria

- Documentation exists indicating that the member is unresponsive to trials of effective medications of adequate dose and duration that are indicated for the member's condition (e.g., anti-depressants, anti-psychotics, etc., as appropriate).
AND
- The member is unable to tolerate effective medications or has a medical condition for which medication is contraindicated.
AND
- The member has had favorable responses to ECT in the past, and rapid response symptom alleviation is medically necessary.
AND
- The member 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, etc.).
AND
- The member is experiencing severe mania or depression during pregnancy.
OR
- The member and the psychiatrist have agreed that ECT is the least restrictive treatment to effectively treat acute and persistent symptoms.

2. Continued Service Criteria

- Despite reasonable therapeutic efforts, clinical findings indicate at least one of the following:
 - Persistence of problems or emergence of new problems that meet the outpatient criteria for electroconvulsive treatment as outlined in the admission criteria.
 - Attempts to discharge to a less-intensive treatment will or can be reasonably expected, based on member history and/or clinical findings, to result in exacerbation or worsening of the member's condition.
 - Clinical information is present, indicating a pending decompensation in the absence of the treatment; or
 - Robust medication management has not been sufficient to stabilize symptoms without the addition of ECT.

3. Discharge Criteria

- The member no longer meets clinical criteria for admission to ECT treatment.
AND

- The member is able to respond effectively to a less intrusive treatment intervention.
4. Clinical Best Practices
- Evaluation and Service Planning
 - Initial Diagnostic Interview by a licensed professional completed within 12 months prior to service initiation or upon beginning a new treatment episode, with ongoing assessment as needed.
 - The IDI shall serve as the initial treatment plan until the comprehensive treatment plan is developed.
 - An individualized treatment plan must be developed prior to treatment and include all of the following:
 - Specific medications to be administered during ECT;
 - Choice of electrode placement during ECT; and
 - Stimulus dosing using a recognized method to produce an adequate seizure while minimizing adverse cognitive side effects.
 - The treatment plan allows for the lowest frequency of treatments that supports sustained remission and/or prevents worsening of symptoms.
 - Service Delivery
 - All of the following are required prior to the initial treatment:
 - A clinical summary prior to treatment consisting of a DSM (current edition) diagnosis that includes but is not limited to:
 - Current and recent symptom of severity supporting indications for ECT;
 - Psychiatric history with mental status;
 - Current functioning to include specific detailed evidence of past response to ECT, and medication trials and response; and
 - Medical history and examination focusing on neurological, cardiovascular and pulmonary systems, current medical status, current medications, dental status, review of laboratory tests including electrocardiogram, if any, within 30 days prior to initiation of ECT.
 - Documentation of an anesthetic evaluation performed by an anesthesiologist or other qualified anesthesiology professional, to include:
 - The member's response to prior anesthetic inductions and any current anesthesia complications or risks; and
 - Required modifications in medications or standard anesthetic technique.
 - There is continuous physiologic monitoring during ECT treatment, addressing:
 - Seizure duration, including missed, brief and/or prolonged seizures, or lack of attaining desired seizure activity;
 - Electroencephalographic activity;
 - Vital signs;
 - Oximetry;
 - Cardiovascular effects;
 - Respiratory effects, including prolonged apnea; and
 - Other monitoring specific to the needs of the member.
 - There are post-ECT stabilization and recovery services, including:
 - Medically supervised stabilization services in the treatment area until vital signs and respiration are stable and no adverse effects such as headache, muscle soreness and nausea are observed; and
 - Recovery services under the supervision of the anesthesia provider with continuous nursing observation and care; monitoring of vital signs including heart, respiration; pulse oximetry; and electrocardiogram if indicated.
 - Discharge Planning
 - Duration of the service is individualized and must be medically necessary as determined based upon the psychiatrist's assessment and the member's response to treatment and according to the treatment plan.

FUNCTIONAL BEHAVIORAL ASSESSMENT

A Functional Behavioral Assessment (FBA) refers to a range of strategies used in the process of determining why a member engages in significant behavioral disruption and how the behavior relates to the environment. The focus of a Functional Behavioral Assessment is on identifying significant, member-specific factors associated with the occurrence (and non-occurrence) of specific behaviors.

Functional Behavioral Assessments provide the practitioner with information necessary to develop a clinical formulation as to why the member engages in the behavior, when the member is most likely to demonstrate the behavior, and situations in which the behavior is most likely and least likely to occur. Generally, members with behavioral issues or functional impairments cannot adequately communicate why they are displaying particular behaviors or what they need to improve functional skills. By gathering data and conducting evaluations of environmental variables on the member'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 intervention with the member and their caregivers that can help the member acquire needed skills and reduce problematic behaviors.

1. Admission Criteria

- The Functional Behavioral Assessment is necessary in order to identify and address problematic behaviors in the youth's functioning that are attributed to developmental, cognitive and/or communication impairments.
AND
- The recommendation for this Functional Behavioral Assessment is being made by a clinician (i.e., pediatrician or behavioral health professional) who has identified that the youth's clinical presentation and functional impairments need specialized behavioral assessment, treatment planning and interventions.
AND
- Other assessments, such as an Initial Diagnostic Interview, would be insufficient to fully identify the root cause of the problematic behaviors or to develop a thorough behavioral modification/behavior replacement plan.
AND
- The youth's maladaptive functioning requires assessment by a provider with specific expertise and training in behavioral assessment and modification therapies to develop appropriate treatment intervention strategies.
AND
- The member presents with severe behaviors that cause significant impairments in all domains of the member's life and, without specialized behaviorally-focused assessment and treatment to address, will likely lead to disrupted placement in school and living environment.
AND
- The member's clinical condition causes an absence in critical skills of self-care, social interaction and/or safety awareness, and the FBA is expected to identify those deficits and the treatment recommendations/interventions to support functional improvement and skill development.
AND
- The member is authorized for medically necessary intensive and/or specialized treatment to address these significant behavior impairments and the FBA is necessary to inform treatment planning approaches.

2. Discharge Criteria

- The therapists will determine the function of the maladaptive behavior and use the information from the assessment to design an effect treatment plan to teach the member functional behaviors to replace the maladaptive behaviors. As a result, the member will improve their ability to interact within the family, social, and educational constructs of their daily life.

3. Clinical Best Practices

- Evaluation and Service Planning
 - An Initial Diagnostic Interview must be completed first and must identify the need for the FBA.

- The FBA must occur prior to the initiation of treatment interventions and must include reviewing situational variables, including environmental circumstances, member caretaker management practices, physical health considerations, and academic and social demands.
- Direct Assessment and Data Analysis are required assessment techniques for this service and are defined as:
 - Direct Assessment – In-person observation and recording of situational factors and the member’s behaviors.
 - Data Analysis – Comparison and analysis of collected data must be completed to determine whether or not there are patterns associated with the behavioral, emotional and mental health conditions of interest.
- The FBA must describe the relationship between the significant behavioral disruption(s) and environmental, cognitive, and/or emotional variables that contribute to its occurrence.
- The FBA must be conducted by a psychologist or other independent licensed and/or certified practitioner with specific training and expertise in conducting FBAs.
- The FBA must identify strengths, problems and needs, goals and objectives, and determine appropriate strategies and methods of behavioral intervention for the member.
- The FBA must include, but is not limited to, the following components:
 - Reason for assessment/Presenting issue;
 - Relevant bio-psychosocial and developmental information;
 - Relevant treatment history/response to treatment efforts;
 - Identification of the disruptive behavior;
 - Definition of the behavior in concrete terms;
 - Identification of the contextual factors that contribute to the disruptive behavior (including affective and cognitive factors);
 - Strengths and resources the youth and family have;
 - Explanation of data collection methodology; in most cases a combination of natural observation across multiple settings, use of validated rating scales/ tools, parent/caregiver interviews, etc., will be used to ensure thorough assessment of problem behaviors;
 - Data and assessment summary to include: a description of problem behaviors; identification of antecedents, predictors, consequences and reinforcers that maintain the behavior; clinical formulation regarding the general condition under which the disruptive behavior usually occurs and probable behavioral and social consequences that serve to maintain the disruptive behavior; and
 - Targeted behavior management plan including the targeted problematic behavior, positive and negative reinforcement findings, behavior replacement/modification interventions, plan monitoring, data collection, and review schedule.
- Documentation expectations include a typed report which includes the components listed above resulting in treatment recommendations. The report must be signed by all fully licensed clinicians who participated in the formation of the report, including the Supervising Practitioner, when applicable.
- The FBA must include collateral contact information (with appropriate signed releases) for significant others or family members to gather relevant information about member and family functioning, and through collateral contacts with former and current healthcare providers, friends, and school officials to verify medical and functional history across environments.
- With appropriate releases of information, it is expected that this assessment will be shared with other professionals involved in the member’s assessment and treatment.

FUNCTIONAL FAMILY THERAPY A Functional Behavioral Assessment (FBA) refers to a range of strategies used in the process of determining why a member engages in significant behavioral disruption and how the behavior relates to the environment. The focus of a Functional Behavioral Assessment is on identifying significant, member-specific factors associated with the occurrence (and non-occurrence) of specific behaviors.

Functional Behavioral Assessments provide the practitioner with information necessary to develop a clinical formulation as to why the member engages in the behavior, when the member is most likely to demonstrate the behavior, and situations in which the behavior is most likely and least likely to occur. Generally, members with behavioral issues or functional impairments cannot adequately communicate why they are displaying particular behaviors or what they need to improve functional skills. By gathering data and conducting evaluations of environmental variables on the member'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 intervention with the member and their caregivers that can help the member acquire needed skills and reduce problematic behaviors.

1. Admission Criteria

- The Functional Behavioral Assessment is necessary in order to identify and address problematic behaviors in the youth's functioning that are attributed to developmental, cognitive and/or communication impairments.
AND
- The recommendation for this Functional Behavioral Assessment is being made by a clinician (i.e., pediatrician or behavioral health professional) who has identified that the youth's clinical presentation and functional impairments need specialized behavioral assessment, treatment planning and interventions.
AND
- Other assessments, such as an Initial Diagnostic Interview, would be insufficient to fully identify the root cause of the problematic behaviors or to develop a thorough behavioral modification/behavior replacement plan.
AND
- The youth's maladaptive functioning requires assessment by a provider with specific expertise and training in behavioral assessment and modification therapies to develop appropriate treatment intervention strategies.
AND
- The member presents with severe behaviors that cause significant impairments in all domains of the member's life and, without specialized behaviorally-focused assessment and treatment to address, will likely lead to disrupted placement in school and living environment.
AND
- The member's clinical condition causes an absence in critical skills of self-care, social interaction and/or safety awareness, and the FBA is expected to identify those deficits and the treatment recommendations/interventions to support functional improvement and skill development.
AND
- The member is authorized for medically necessary intensive and/or specialized treatment to address these significant behavior impairments and the FBA is necessary to inform treatment planning approaches.

2. Discharge Criteria

- The therapists will determine the function of the maladaptive behavior and use the information from the assessment to design an effect treatment plan to teach the member functional behaviors to replace the maladaptive behaviors. As a result, the member will improve their ability to interact within the family, social, and educational constructs of their daily life.

3. Clinical Best Practices

- Evaluation and Service Planning
 - An Initial Diagnostic Interview must be completed first and must identify the need for the FBA.
 - The FBA must occur prior to the initiation of treatment interventions and must include reviewing situational variables, including environmental circumstances,

- member caretaker management practices, physical health considerations, and academic and social demands.
- Direct Assessment and Data Analysis are required assessment techniques for this service and are defined as:
 - Direct Assessment – In-person observation and recording of situational factors and the member’s behaviors.
 - Data Analysis – Comparison and analysis of collected data must be completed to determine whether or not there are patterns associated with the behavioral, emotional, and mental health conditions of interest.
 - The FBA must describe the relationship between the significant behavioral disruption(s) and environmental, cognitive, and/or emotional variables that contribute to its occurrence.
 - The FBA must be conducted by a psychologist or other independent licensed and/or certified practitioner with specific training and expertise in conducting FBAs.
 - The FBA must identify strengths, problems and needs, goals and objectives, and determine appropriate strategies and methods of behavioral intervention for the member.
 - The FBA must include, but is not limited to, the following components:
 - Reason for assessment/Presenting issue;
 - Relevant bio-psychosocial and developmental information;
 - Relevant treatment history/response to treatment efforts;
 - Identification of the disruptive behavior;
 - Definition of the behavior in concrete terms;
 - Identification of the contextual factors that contribute to the disruptive behavior (including affective and cognitive factors);
 - Strengths and resources the youth and family have;
 - Explanation of data collection methodology; in most cases a combination of natural observation across multiple settings, use of validated rating scales/ tools, parent/caregiver interviews, etc., will be used to ensure thorough assessment of problem behaviors;
 - Data and assessment summary to include: a description of problem behaviors; identification of antecedents, predictors, consequences and reinforcers that maintain the behavior; clinical formulation regarding the general condition under which the disruptive behavior usually occurs and probable behavioral and social consequences that serve to maintain the disruptive behavior; and
 - Targeted behavior management plan including the targeted problematic behavior, positive and negative reinforcement findings, behavior replacement/modification interventions, plan monitoring, data collection, and review schedule.
 - Documentation expectations include a typed report which includes the components listed above resulting in treatment recommendations. The report must be signed by all fully licensed clinicians who participated in the formation of the report, including the Supervising Practitioner, when applicable.
 - The FBA must include collateral contact information (with appropriate signed releases) for significant others or family members to gather relevant information about member and family functioning, and through collateral contacts with former and current healthcare providers, friends, and school officials to verify medical and functional history across environments.
 - With appropriate releases of information, it is expected that this assessment will be shared with other professionals involved in the member’s assessment and treatment.

INPATIENT TREATMENT

INPATIENT An Acute Inpatient program is designed to provide medically necessary, intensive assessment, psychiatric treatment and support to members with a DSM (current version) diagnosis and/or co-occurring disorder experiencing an acute exacerbation of a

psychiatric condition. The Acute Inpatient setting is equipped to serve patients at high risk of harm to self or others and in need of a safe, secure, lockable setting. The purpose of the services provided within an Acute Inpatient setting is to stabilize the member's acute psychiatric conditions.

1. Admission Criteria

- The member demonstrates symptomatology consistent with a DSM (current edition) diagnosis which requires and can reasonably be expected to respond to therapeutic intervention.
AND
- The member requires 24 hour access to the full spectrum of psychiatric staffing in a controlled environment that may include but is not limited to medication monitoring and administration, therapeutic intervention, quiet room, restrictive safety measures, and suicidal/homicidal observation and precautions.
AND
- Due to the risk of medical instability the need for confinement beyond 23 hours with intensive medical and therapeutic intervention is clearly indicated.
AND
- There is a clear and reasonable inference of imminent serious harm to self/others as evidenced by having any one of the following:
 - A 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; or
 - Violent unpredictable or uncontrolled behavior is related to the behavioral health disorder and represents an imminent risk of serious harm to self or others;AND
- 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.
AND
- The member 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 member's general medical or mental health.

2. Continued Service Criteria

- The member demonstrates symptomatology consistent with a DSM (current edition) diagnosis which requires and can reasonably be expected to respond to therapeutic intervention.
AND
- The member requires 24 hour access to the full spectrum of psychiatric staffing in a controlled environment that may include but is not limited to medication monitoring and administration, therapeutic intervention, quiet room, restrictive safety measures, and suicidal/homicidal observation and precautions.
AND
- Due to the risk of medical instability the need for confinement beyond 23 hours with intensive medical and therapeutic intervention is clearly indicated.
AND
- There is a clear and reasonable inference of imminent serious harm to self/others as evidenced by having any one of the following:
 - A 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; or
 - Violent unpredictable or uncontrolled behavior is related to the behavioral health disorder and represents an imminent risk of serious harm to self or others;AND
- 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.
AND

- The member 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 member's general medical or mental health.
3. Discharge Criteria
 - Symptoms are stabilized and the member no longer meets clinical criteria for acute care.
AND
 - Sufficient supports are in place and member can safely move to a less restrictive environment.
AND
 - Treatment plan goals and objectives are substantially met.
 4. Clinical Best Practices
 - Evaluation and Service Planning
 - The psychiatrist in conjunction with the treatment team completes the initial evaluation commensurate within 24 hours of admission.
 - The following assessments must be conducted: Initial Diagnostic Interview (IDI), nursing assessments, laboratory, radiological, substance use disorder; physical and neurological exams and other diagnostic tests as necessary.
 - Family members are encouraged to participate in the assessment/treatment of the member as appropriate and approved by the member, and their participation or lack of participation is documented in the member record.
 - Develop and implement a treatment plan with provisions for: resolution of acute medical problems; evaluation of, and needs assessment for, medications; protocol to ensure patient's safety; discharge plan initiated at the time of admission.
The treatment plan must be reviewed weekly or as medically necessary.
 - Service Delivery
 - There is an intensive and comprehensive active treatment program provided that includes professional psychiatric, medical, surgical, nursing, social work, psychological, and activity therapies required to carry out a member treatment plan for each patient and their family.
 - Hospitals which provide inpatient psychiatric services must be staffed with the number of qualified professional, technical, and supporting personnel and consultants required to implement comprehensive assessments and treatment plans.
 - Face to face evaluation and treatment by a physician six out of seven days is required.
Psychiatric nursing interventions are available to patients 24/7
 - Medication management
 - Member, group, and family therapy available and offered as tolerated and/or appropriate.
Social Services to engage in discharge planning and help the member develop community supports and resources and consult with community agencies on behalf of the member
 - Discharge Planning
 - A number of days driven by the medical necessity for a patient to remain at this level of care.

INTENSIVE OUTPATIENT TREATMENT ADULT

INTENSIVE OUTPATIENT TREATMENT ADULTS Intensive Outpatient Services are non-residential, intensive, structured intervention consisting counseling and education regarding the needs of the targeted population. IOP interventions may include: ongoing assessment, individual, group, and family psychotherapy and psycho-educational services. Services are goal oriented interactions in preparing the youth to apply learned skills in "real world" environments.

1. Admission Criteria
 - The member is assessed and meets the diagnostic criteria for a Mental Health Disorder as defined in the most recent DSM.

- AND
 - Difficulty maintaining stability or lack of follow through with a variety of outpatient services necessitating use of IOP to enhance the opportunities and experiences known to improve the possibility of successful stability.
 - AND
 - Of all reasonable options for active psychiatric treatment available to the client, this program must be the best choice for expecting reduction in treatment.
 - AND
 - For individuals who present with co-occurring mental health and substance use disorder symptoms and diagnoses, the provider must refer to the ASAM Criteria (current edition) Intensive Outpatient Level 2.1.
2. Continued Service Criteria
- For adults:
 - The persistence of problems that caused the admission
 - AND
 - The emergence of additional problems that meet the admission criteria.
 - AND
 - Reasonable improvement in the client's psychiatric condition.
 - AND
 - Attempts at therapeutic re-entry into a less-intensive level of care have resulted in, or would result in exacerbation of the referral reason to the degree that would necessitate continued intensive outpatient treatment.
3. Discharge Criteria
- The member has met the treatment plan goals and objectives.
 - AND
 - The precipitating condition and relapse potential is stabilized such that member's condition can be managed without professional external supports and intervention.
 - AND
 - The member is able to remain stable a less intensive level of treatment or support.
 - AND
 - The member has support systems secure to help them maintain stability
4. Clinical Best Practices
- Evaluation and Service Planning
 - An Initial Diagnostic Assessment (IDI) and a Substance Use Disorder Assessment by a licensed clinician prior to the beginning of treatment.
 - The IDI shall serve as the initial treatment plan until the comprehensive treatment plan is developed.
 - Individualized treatment/recovery plan, including discharge and relapse prevention, developed with the individual within the first 2 appointments with the provider.
 - Service Delivery
 - Therapies/interventions should include individual, family, and group psychotherapy, educational groups, motivational, enhancement and engagement strategies.
 - Provision of 9 or more hours per week of skilled treatment, with at least three hours of availability per day. Scheduled hours at minimum are three times per week, and may be available up to seven days per week.
 - Review and update of the treatment/recovery plan under clinical guidance with the individual and other approved family/supports every 30 days or more often as medically indicated.
 - Access to a licensed mental health/substance abuse professional on a 24/7 basis.
 - Other services could include 24 hours crisis management, family education, self-help group and support group orientation.
 - Therapists of members with more than one mental health/substance use disorder provider must communicate with and document coordinated services with any other mental health/substance provider for the family or individual family members.
 - Monitoring stabilized comorbid medical and psychiatric conditions.

- Consultation and/or referral for general medical, psychiatric, needs.
- Discharge Planning
 - Length of service is individualized and based on clinical criteria for admission and continuing stay. The frequency and duration varies according to the individual needs of the client and the client's response to the day-to-day treatment intervention.

INTENSIVE OUTPATIENT TREATMENT YOUTH

INTENSIVE OUTPATIENT TREATMENT YOUTH

Intensive Outpatient Services are non-residential, intensive, structured intervention consisting counseling and education regarding the needs of the targeted population. For youth, Intensive Outpatient Services consist of services to improve the mental health, sexually harmful behavior, substance use disorder and /or eating disorder symptoms that may significantly interfere with functioning in at least one life domain (e.g., familial, social, occupational, educational, etc.). IOP interventions may include: ongoing assessment, individual, group, and family psychotherapy and psycho-educational services. Services are goal oriented interactions in preparing the youth to apply learned skills in "real world" environments.

1. Admission Criteria

- The youth is assessed and meets the diagnostic criteria for a Mental Health or Substance Use Disorder as defined in the most recent DSM.
AND
- Difficulty maintaining stability or lack of follow through with a variety of outpatient services necessitating use of IOP to enhance the opportunities and experiences known to improve the possibility of successful stability.
AND
- Of all reasonable options for active psychiatric or substance abuse treatment available to the client, this program must be the best choice for expecting reduction in treatment.
AND
- For individuals who present with co-occurring mental health and substance use disorder symptoms and diagnoses, the provider must refer to the ASAM Criteria (current edition) Intensive Outpatient Level 2.1.

2. Continued Service Criteria

- The member is making progress but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at this level of care is assessed as necessary to permit the member to continue to work toward his or her treatment goals.
OR
- The member is not yet making progress, but has the capacity to resolve his or her problems. The member is actively working toward the goals in the individualized treatment plan. Continued treatment at this level of care is assessed as necessary to permit the member to continue to work toward his or her treatment goals.
AND/OR
- New problems have been identified that are appropriately treated at this level of care. This level of care is the least intensive level of care at which the member's new problems can be addressed effectively.

3. Discharge Criteria

- The individual has met the treatment plan goals and objectives.
AND
- The precipitating condition and relapse potential is stabilized such that individual's condition can be managed without professional external supports and intervention.
AND
- Individual is able to remain stable a less intensive level of treatment or support.
AND
- Individual has support systems secure to help them maintain stability

4. Clinical Best Practices

- Evaluation and Service Planning
 - If indicated, an Initial Diagnostic Assessment (IDI) and a Substance Use Disorder Assessment is completed by a licensed clinician prior to the beginning of treatment.
 - The IDI should be completed for youth exhibiting Eating Disorders or sexually harmful behaviors.
 - The IDI may serve as the initial treatment plan until the comprehensive treatment plan is developed.
 - Individualized treatment/recovery plan, including discharge and relapse prevention, developed with the individual within 14 days.
 - IOP programs may be developed with a particular focus to treat a mental health co-occurring, and other co-occurring diagnoses such as eating disorders, or dysfunctions such as sexual offending.
- Service Delivery
 - Therapies/interventions should include individual, family, and group psychotherapy, educational groups, motivational, enhancement and engagement strategies.
 - Provision of 9 or more hours per week of skilled treatment, with at least three hours of availability per day. Scheduled hours at minimum are three times per week, and may be available up to seven days per week.
 - Review and update of the treatment/recovery plan under clinical guidance with the individual and other approved family/supports every 30 days or more often as medically indicated.
 - Access to a licensed mental health/substance abuse professional on a 24/7 basis.
 - Other services could include 24 hours crisis management, family education, self-help group and support group orientation.
 - Therapists of members with more than one mental health/substance use disorder provider must communicate with and document coordinated services with any other mental health/substance provider for the family or individual family members.
 - Monitoring stabilized comorbid medical and psychiatric conditions.
 - Consultation and/or referral for general medical, psychiatric, needs.
- Discharge Planning
 - Length of service is individualized and based on clinical criteria for admission and continuing stay. The frequency and duration varies according to the individual needs of the client and the client's response to the day-to-day treatment intervention.

MULTISYSTEMIC THERAPY

MULTISYSTEMIC THERAPY

MST is an evidenced based intensive treatment process that focuses on diagnosed behavioral health disorders and on environmental systems (family, school, peer groups, culture, neighborhood and community) that contribute to, or influence a youth's involvement, or potential involvement in the juvenile justice system. The therapeutic modality reinforces positive behaviors, and reduces negative behavior, uses family strengths to promote positive coping activities and helps the family increase accountability and problem solving. Beneficiaries accepting MST receive assessment and home based treatment that strives to change how youth, who are at risk of out-of-home placement or who are returning home from an out of home placement, function in their natural settings to promote positive social behavior while decreasing anti-social behavior.

MST's therapeutic model aims to uncover and assess the functional origins of adolescent behavioral problems by altering the youth's bio-psychosocial system in a manner that promotes prosocial conduct while decreasing aggressive/violent, antisocial, substance using or delinquent behavior by keeping the youth safely at home, in school and out of trouble. Treatment is used at the onset of behaviors that could result in (or have resulted in) criminal involvement by treating the youth within the environment that has formed the basis of the problem behavior.

1. Admission Criteria

- The member is not in imminent or current risk of harm to self, others, and/or property.
AND
- The target age of the member is 12-17 years old.
AND
- The member exhibits significant externalizing behavior, such as chronic or violent juvenile offenses.
AND
- The member is at risk for out-of-home placement or is transitioning back from an out-of-home setting
AND
- The member has externalizing behaviors and symptomatology resulting in a DSM-5 diagnosis of Conduct Disorder or other diagnoses consistent with such symptomatology.
AND
- There is ongoing multiple system involvement due to high risk behaviors and/or risk of failure in mainstream school settings due to behavioral problems.
AND
- Less intensive treatment has been ineffective or is inappropriate.
AND
- One of the following must be met in addition to the mandatory criteria:
 - The member with behavioral health issues manifests in outward behaviors that negatively impact multiple systems (e.g., family, school, community); or
 - Members with substance use disorder issues may be included if they meet the mandatory criteria, and MST is deemed clinically more appropriate than focused drug and alcohol treatment.

2. Continued Service Criteria

- Members receiving MST services must meet all of the following criteria for continuing treatment with MST:
 - Treatment does not require more intensive level of care.
AND
 - The treatment plan has been developed, implemented and updated based on the member's clinical condition and response to treatment, as well as the strengths of the family, with realistic goals and objectives clearly stated.
AND
 - Progress is clearly evident in objective terms, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address the lack of progress are evident.
AND
 - The family is actively involved in treatment, or there are active, persistent efforts being made which are expected to lead to engagement in treatment.

3. Discharge Criteria

- Members who meet the following criteria no longer meet medical necessity criteria for MST and shall be discharged from MST treatment:
 - The member's treatment plan goals or objectives have been substantially met.
AND
 - The member meets criteria for a higher or lower level of treatment, care or services.
AND
 - The member, family, guardian and/or custodian are not engaging in treatment or not following program rules and regulations, despite attempts to address barriers to treatment.
AND
 - Consent for treatment has been withdrawn, or the member and/or family have not benefitted from MST, despite documented efforts to engage, and there is no reasonable expectation of progress at this level of care, despite treatment.

4. Clinical Best Practices

- Evaluation and Service Planning

- An Initial Diagnostic Interview (IDI) must be completed prior to the beginning of treatment and will serve as the initial treatment plan until a comprehensive treatment plan is completed.
- Assessments and treatment should address mental health/substance abuse needs, and mental health and/or emotional issues related to medical conditions.
- The treatment plan must be individualized and must include the specific problems, behaviors, or skills to be addressed; clear and realistic goals and objectives; services, strategies, and methods of intervention to be implemented; criteria for achievement; target dates; methods for evaluating the individual's progress; and the responsible professional.
- The treatment plan must be developed with the individual and the identified, appropriate family members as part of the outpatient family therapy treatment planning process.
- Treatment plans must be reviewed every 90 days or more often if clinically indicated.
- Service Delivery
 - The treating provider must consult with and/or refer to other providers for general medical, psychiatric, and psychological needs as indicated.
 - It is the provider's responsibility to coordinate with other treating professionals as needed.
 - All psychiatric/psychotherapy services must be prescribed and provided under the supervision and direction of a supervising practitioner (Physicians; Licensed Psychologists; and/or Licensed Independent Mental Health Practitioners). Supervision is not a billable service.
 - Supervision entails: 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. Involvement of the supervising practitioner must be reflected in the Initial Diagnostic Interview the treatment plan and the interventions provided.
 - After hours crisis assistance must be available.
 - Services must be trauma informed, culturally sensitive, age and developmentally appropriate and incorporate evidence based practices when appropriate.
 - Therapeutic contacts emphasize the positive and use systemic strengths as levers for change.
 - Interventions are designed to promote responsible behavior and decrease irresponsible behavior among family members.
 - Interventions are present-focused and action-oriented, targeting specific and well-defined problems.
 - Interventions target sequences of behavior within and between multiple systems that maintain the identified problems.
 - Interventions are developmentally appropriate and fit the developmental needs of the member.
 - Interventions are designed to require daily or weekly efforts by family members.
 - Intervention effectiveness is evaluated continuously from multiple perspectives, with the provider assuming accountability for overcoming barriers to successful outcomes.
 - Interventions should be designed to promote treatment generalization and long-term maintenance of therapeutic change by empowering caregivers to address family members' needs across multiple systemic contexts.
 - MST is designed to accomplish the following:
 - Reduce the frequency of referral behaviors and increase pro-social behaviors, reduce symptoms, maladaptive and externalizing behaviors, so that the child/youth can be treated in a lower level of community-based care. Child/youth no longer demonstrating ongoing risk of deliberate attempts to inflict serious injury on self or others.

- Decrease association with deviant peers and increase association with pro-social peers and involvement in positive recreational activities.
- Help caregivers develop effective parenting skills and skills to manage the member's mental health needs, improve caregiver decision-making and limit setting.
- Improve family relationships.
- Improve school or vocational success, as indicated by improved grade point average, a decrease in disciplinary referrals, unexcused absences and tardiness and/or a decrease in job terminations.
- Support involvement in restorative measures, such as community services, if involved with Juvenile Justice (Office of Children, Youth and Families resources will oversee and fund the participation in restorative measures, rather than the MST service provider).
- Reduce likelihood of out-of-home placement and reduce the utilization of out-of-home therapeutic resources (i.e., therapeutic foster care, residential treatment facility, etc.).
- Develop natural supports for the member and family.
- Specific treatment goals will always be individualized and tied to behavioral health needs.
- On average, families receive about 60 hours of face-to-face treatment over a four-month period, as well as about 35 hours of non-direct contact provided to the ecology of the youth (e.g., consultation and collaboration with other systems).
- Services occur in the family's home or community at times that are convenient for the family. Therapists and/or their supervisors are on call for families 24/7. Supervisors are available to therapists around-the-clock for support.
- Each therapist carries a small caseload (four to six families) at any one time.
- Discharge Planning
 - Length of treatment is individualized and based on the progress of the youth and family according to their treatment goals. Average number of sessions is 60. A number of days driven by the medical necessity for a patient to remain at this level of care.

NEBRASKA THERAPEUTIC COMMUNITY-FAMILY BASED SUPPORT

THERAPEUTIC COMMUNITY Therapeutic Community is intended for adults with a primary substance use disorder for whom shorter term treatment is inappropriate, either because of the pervasiveness of the impact of substance use disorder on the member's life or because of a history of repeated short-term or less restrictive treatment failures. This service provides psychosocial skill building through a set of longer term, highly structured treatment strategies that define progress toward member change and rehabilitation. The member's progress is to be marked by advancement through these phases to less restriction and more personal responsibility.

FAMILY-BASED THERAPEUTIC COMMUNITY The Family-Based approach to Therapeutic Community allows parents with substance use disorders and if present, a co-occurring mental health diagnosis, to keep their children with them while in residential treatment. Family-based treatment programs consider the family unit as a whole and provide services to both children and families as a part of the substance abuse treatment plan so that the family does not need to be separated in order for the member to receive benefit from treatment and recovery services.

1. Admission Criteria

- The member meets the diagnostic criteria for a substance-related disorder, as defined in the DSM (current edition), as well as the ASAM six dimensional criteria for admission. The ASAM Criteria should be used to complete dimensional criteria.
AND
- The member is likely to benefit from Community Support in his/her home and community.
AND
- Criteria for Family Therapeutic Community includes all of the following:

- There is a need for a family-based treatment approach to therapeutically support a child as well as the member in a residential treatment setting while the member receives substance abuse treatment.
 - Without a family-based treatment approach the family and child are at high risk of child abuse, neglect, developmental problems, and/or adolescent substance use.
 - The member may be at risk of not entering or exiting treatment as a result of separation from his/her child.
 - There is a need for the member as a part of his/her treatment to learn to effectively parent sober or receive the appropriate treatment and care in order to have a safe birth and delivery.
2. Continued Service Criteria
- It is appropriate to retain the member at the present level of care if:
 - The member is making progress but has not yet achieved the goals articulated in the treatment plan.
 - Continued treatment at this level of care is assessed as necessary to permit the member to continue to work toward his or her treatment goals;
 - The member is not yet making progress, but has the capacity to resolve his or her problems.
 - The member is actively working toward the goals in the treatment plan; and/or
 - New problems have been identified that are appropriately treated at this level of care.
 - This level of care is the least intensive level of care at which the member's new problems can be addressed effectively.
3. Discharge Criteria
- The member has met their treatment plan goals and objectives.
AND
 - The precipitating condition and relapse potential is stabilized such that member.s condition can be managed without professional external supports and interventions.
AND
 - The member has alternative support systems secured to help the member maintain stability in the community.
4. Clinical Best Practices
- Evaluation and Planning
 - A substance use disorder (SUD) assessment by a licensed clinician prior to the beginning of treatment.
 - If a prior SUD assessment is determined to be clinically relevant and includes a current diagnosis, level of care recommendation and a discharge plan it can serve as the admission assessment. If the prior assessment is not relevant or does not contain the necessary information than an SUD addendum would be necessary.
 - All members are to be screened for co-occurring conditions throughout the assessment. If the clinician is a LADC or a PLADC and suspects a possible mental health condition, a referral is to be made to a clinician capable of diagnosing/treating co-occurring mental health and substance use disorders.
 - Individualized treatment/recovery plan, including discharge and relapse prevention, developed under clinical supervision with the member (consider community, family and other supports) developed within seven days of admission to guide the first 30 days of treatment.
 - Review and update of the treatment/recovery plan under clinical supervision with the member and other approved family/supports every 30 days or more often as clinically indicated.
 - Service Delivery
 - Consultation and/or referral for general medical, psychiatric, psychopharmacology and psychological needs.
 - Monitoring stabilized co-occurring mental health problems.

- A minimum of 30 hours of treatment and recovery focused services weekly including member, family, and group psychotherapy, educational groups, motivational enhancement and engagement strategies.
- The therapy will offer planned clinical activities designed to stabilize the member's mental health problem and psychiatric symptoms and to maintain a stable life.
- The goals of therapy apply to both the substance use disorder and any co-occurring mental health disorder. Specific attention is given to medication education and management.
- Treatment is directed toward overcoming the member's lack of awareness of the effects of substance-related problems on their lives, as well as enhancing their readiness to change.
- Treatment is focused on preventing relapse, continued problems and/or continued use, and promoting the eventual reintegration of the member into the community.
- Monitoring to promote successful reintegration into regular, productive daily activity such as work, school or family living.
- Family Therapeutic Community interventions:
 - Assure children's safety,
 - Assist the parent in accessing needed medical services and child care,
 - Assess infant/children's developmental and educational needs, and
 - Ensure that a plan has been put into place to meet all special needs that the children may have. The program not only addresses the children's special needs that have resulted from a mother's use during pregnancy, but it will also assist her in processing the shame and grief that comes with her child's special needs.
 - Provide parenting/modeling groups
 - Provide family therapy with parent(s) and child
 - Provide children play therapy groups
 - Provide parent and children family activity time-which may clinical staff participation to model/direct/support treatment issues relevant to parenting and learning to live successfully as a sober parent
 - Provide structured family interaction therapy
 - Provide parenting Classes (including Love & Logic, Nurturing Parent, Circle of Security)
 - Have family Team Meetings
 - Provide family Case Management
- Discharge Planning
 - Length of service is individualized and based on clinical criteria for admission and continued stay, as well as the client's ability to make progress on member treatment/recovery goals.

OBSERVATION ROOM

OBSERVATION ROOM Emergency Psychiatric Observation provides less than 24 hours of care in a secure, medically supervised hospital setting for evaluation and stabilization of acute psychiatric and/or substance use disorder symptoms.

1. Admission Criteria

- The member presents with symptoms consistent with a psychiatric or substance use disorder crisis that requires a period of observation, assessment and treatment.
AND
- The member's medical needs are stable.
AND
- The member does not appear to require greater than 23:59 treatment or inpatient level of care.
AND
- Based on current information, there may be a lack of diagnostic clarity and further evaluation is necessary to determine the member's service needs.

2. Continued Service Criteria
 - If it is determined that continued care is needed beyond the 24 hour period, the member is considered as inpatient hospitalization and prior authorization requirements apply.
3. Discharge Criteria
 - Symptoms are stabilized and the member no longer meets clinical criteria.
AND
 - Sufficient supports are in place and the member can return to a less restrictive environment.
AND
 - Admission to a higher level of care if medically appropriate.
4. Clinical Best Practices
 - Evaluation and Service Planning
 - Complete a trauma-informed mental health assessment beginning with a face-to-face, initial diagnostic interview and continuing with an emergency psychiatric observation level of care during a period of less than 24 hours.
 - A substance use disorder screening is completed during the observation period.
 - A health screening/nursing assessment is conducted by a Registered Nurse.
 - A discharge plan, with emphasis on crisis intervention and referral for relapse prevention and other services developed under the direction of a physician (psychiatrist preferred).
 - Provide medication evaluation and management services.
 - Discharge Planning
 - Less than 24 hours

OUTPATIENT ASSESSMENT & TREATMENT

OUTPATIENT ASSESSMENT AND TREATMENT

Assessment

- **Initial Diagnostic Interview –The Initial Diagnostic Interview is used to identify the problems and needs, develop goals and objectives, and determine appropriate strategies and methods of intervention for the client. The Initial Diagnostic Interview shall include a history, mental status, and a disposition.**
- **Family Assessment – The Family assessment is a process for gathering and organizing information that involves exploration of family structure and composition as well as member relationships, characteristics, interactions, and dynamics. A thorough family assessment is the foundation in setting clear, specific, and achievable goals.**

Treatment

- **Individual Therapy**
 - **Outpatient psychotherapy is the treatment of psychiatric and substance abuse disorders through scheduled therapeutic visits between the therapist and the individual. The focus of outpatient psychotherapy treatment is to improve or alleviate symptoms that may significantly interfere with functioning in at least one life domain (e.g., familial, social, occupational, educational, etc.). Medicaid does not reimburse for psychotherapy for self-actualization or maintenance care purposes. The goals, frequency, and duration of outpatient treatment will vary according to individual needs and response to treatment.**
- **Family Therapy**
 - **Outpatient family psychotherapy is a therapeutic encounter between the licensed treatment professional and the individual, and the nuclear or the extended family. The specific objective of treatment must be to alter the family system to increase the functional level of the identified individual/family by focusing services/interventions on the systems within the family unit. This therapy must be provided with the appropriate family members and the individual.**
- **Group Therapy**

- **Outpatient group psychotherapy is the treatment of psychiatric/substance abuse disorders through scheduled therapeutic visits between the therapist and the patient in the context of a group setting of at least three and no more than twelve individual participants with a common goal. The focus of outpatient group psychotherapy treatment is to improve or an individual's ability to function as well as alleviate symptoms that may significantly interfere with their interpersonal functioning in at least one life domain (e.g., familial, social, occupational, educational, etc.). Group therapy must provide active treatment for a primary DSM (current version) diagnosis. The goals, frequency, and duration of outpatient group treatment will vary according to individual needs and response to treatment.**
- **Medication Management**
 - **Medication Management is the level of outpatient treatment where the sole service rendered by a qualified prescriber is the evaluation of the individual's need for psychotropic medications, provision of a prescription, and ongoing medical monitoring of those medications.**
- **Supervision**
 - **Supervisions by the supervising practitioner is the critical oversight of a treatment activity and directing the patient care. This includes, but is not limited to, review of treatment plan and progress notes, individual specific case discussion, and annual face to face assessments of the individual.**
 - **The supervising practitioner is a source of information and guidance for all members of the treatment team and their participation in services as an essential ingredient for all members of the treatment. The critical involvement of the supervising practitioner must be reflected in the Initial Diagnostic Interview, the treatment plan, and the interventions provided.**

1. Admission Criteria

- The individual demonstrates symptomatology consistent with a DSM (current edition) diagnosis which requires and can reasonably be expected to respond to therapeutic intervention.
AND
- There are significant symptoms, caused by the behavioral health/substance abuse disorder diagnosis, that interfere with the individual's ability to function in at least one life area.
AND
- This level of care is the least restrictive setting that will produce the desired results in accordance with the needs of the individual.
AND
- There is an expectation that the individual has the capacity to make significant progress toward treatment goals to where services are no longer necessary.
AND for Family Therapy
- Family therapy is required for reasons other than primarily for the convenience of the individual or the provider.
AND
- Family therapy is recommended through thorough assessments completed by licensed clinicians as medically necessary to achieve goals/objectives for treatment of a behavior health/substance-related condition.
AND for Group Therapy
- The individual participant has an interpersonal problem related to their diagnosis and functional impairments.
AND
- There is an expectation that the individual has the capacity to make significant progress toward treatment goals from interactions with others who may have a similar experience.
AND
- The individual has the competency to function in a group therapy.
AND
- The individual has a therapeutic goal common to the group.

- AND
 - The individual may benefit from confrontation by and/or accountability to a group of peers.
 - AND
 - This level of care is the least restrictive setting that will produce the desired results in accordance with the needs of the client.
 - AND for Medication Management**
 - There is a need for prescribing and monitoring psychotropic medications.
2. Continued Service Criteria
- The individual's condition continues to meet admission Guidelines at this level of care.
 - AND
 - The individual's treatment does not require a more intensive level of care, and no less intensive level of care would be appropriate.
 - AND
 - Treatment planning is individualized and appropriate to the individual's changing condition, with realistic and specific goals and objectives clearly stated.
 - AND
 - All services and treatment are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice.
 - AND
 - Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address lack of progress are evident.
 - AND
 - Care is rendered in a clinically appropriate manner and focused on the individual's behavioral and functional outcomes as described in the discharge plan.
 - AND
 - When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated.
 - AND
 - There is documented active discharge planning.
3. Discharge Criteria
- The individual has substantially met their treatment plan goals and objectives
 - AND
 - Individual is able to remain stable in the community without this treatment.
 - AND
 - Individual has support systems secured to help the individual maintain stability in the community
4. Clinical Best Practices
- Evaluation and Service Planning
 - The Initial Diagnostic Interview (IDI) must include:
 - The assessment must include but is not limited to the following information:
 - Reason client is seeking services
 - Comprehensive Mental Status Exam that supports the treatment diagnosis, including recommendations for active treatment interventions.
 - DSM Diagnosis (current version)
 - History & symptomology consistent with DSM (current version) criteria
 - Psychiatric treatment history
 - Current and past suicide/homicide danger risk assessed
 - Level of familial supports assessed and involved as indicated
 - Identified areas for improvement
 - Assessment of strengths, skills, abilities, motivation etc.
 - Medical history
 - All current medications with dosages
 - The Family Assessment includes:
 - Internal, as well as external factors that affect the family.

- Identification of family strengths and needs in order to develop a plan with the family that contains measurable outcomes to assist them with problem solving within the context of their family unit.
 - Specific enough to serve as the basis for a treatment plan geared to the particular family.
- Treatment Plan:
 - An individualized treatment/recovery plan must be developed within two sessions of the assessment.
 - The treatment plan must be individualized to the client and must include the specific problems, behaviors, or skills to be addressed; clear and realistic goals and objectives; services, strategies, and methods of intervention to be implemented; criteria for achievement; target dates; methods for evaluating the client's progress; and the responsible professional.
 - Individual, family and group therapy treatment plans must be reviewed every 90 days or more often if clinically indicated.
- Outpatient Therapy
 - Consultation and/or referral for general medical, psychiatric, psychological, and psychopharmacology needs
 - It is the provider's responsibility to coordinate with other treating professionals as needed
 - All psychotherapy services must be provided under the supervision and direction of a supervising practitioner (Physicians; Licensed Psychologists; and/or Licensed Independent Mental Health Practitioners)
 - All psychotherapy services provided by allied health therapists must be prescribed by the supervising practitioner and provided under their supervision. Allied health therapists include: Specially Licensed Psychologists; Licensed and/or provisionally licensed Mental Health Practitioners; and Qualified Mental Health Professional/Masters Equivalent. (Supervision is not a billable service).
 - Supervision entails: critical oversight of a treatment activity or course of action; review of the treatment plan and progress notes; client specific case discussion; periodic assessments of the client; and diagnosis, treatment intervention or issue specific discussion. Involvement of the supervising practitioner must be reflected in the Initial Diagnostic Interview the treatment plan and the interventions provided.
 - After hours crisis assistance must be available
 - Family Therapy
 - Family therapy without the member present should be a purposeful intervention identified in the treatment plan and must have corresponding progress notes in the chart documentation.
 - This service is not meant to provide reimbursement for information sharing between the provider and family members or to provide other non-covered services (parent education, couples counseling) or to provide services to non-covered individuals (individual therapy to a non-Medicaid covered parent(s)).
 - Medication Management
 - Medication evaluation and documentation of monitoring
 - Medication monitoring routinely and as needed
 - Client education pertaining to the medication to support the individual in making an informed decision for its use.
 - The service provider must make a documented attempt with client's permission to coordinate care with the individual's medical and/or clinical providers.
 - Supervision Expectations
 - Provide face-to-face service to the individual at least annually or as often as medically necessary or otherwise mandated.
 - Provide the therapist with recommendations for medically necessary treatment.

- Direct patient care by reviewing and approving individual specific treatment plans and progress notes within the timelines specified for each level of care.
- Assure treatment provided meets standards of care.
- The supervising practitioner must be available, in person or by telephone, to provide assistance and direction as needed during the time the services are being provided.
- Supervision must be provided within the scope of practice of the individual supervising practitioner.
- Discharge Planning
 - Length of treatment is individualized and based on clinical criteria for admission and continued treatment, as well as the client's ability to benefit from individual treatment/recovery goals.

PARENT-CHILD INTERACTION THERAPY

PARENT-CHILD INTERACTION THERAPY An evidence-based service provided to children age 2-12. This therapy places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns. As such, it is used to treat clinically significant disruptive behaviors due to the child's primary mental health disorder. Participation of the caregiver in each session is a necessary component of treatment.

1. Admission Criteria

- The member demonstrates symptomatology consistent with a DSM (current edition) diagnosis which requires and can reasonably be expected to respond to therapeutic intervention.
AND
- There are significant symptoms, caused by the behavioral health diagnosis, that interfere with the member's ability to function in at least one life area.
AND
- This service is provided in the least restrictive setting that will produce the desired results in accordance with the needs of the member.
AND
- There is an expectation that the member has the capacity to make significant progress toward treatment goals to the point that services are no longer necessary.
AND
- PCIT is required for reasons other than primarily for the convenience of the member or the provider.
AND
- PCIT involves the member and his/her family with a therapist for the purpose of improving a behavioral health condition, focusing on the level of family functioning as a whole and addressing issues related to the entire family system.
AND
- Family therapy is recommended through thorough assessments completed by licensed clinicians as medically necessary to achieve goals/objectives for treatment of a behavior health condition.

2. Continued Service Criteria

- Admission criteria continue to be met.
AND
- Treatment planning is individualized and appropriate to the family's changing condition, with realistic and specific goals and objectives clearly stated.
AND
- All services and treatment are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice.
AND
- Progress in relation to specific dysfunction is clearly evident and can be described in objective terms, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address lack of progress are evident.
AND

- Care is rendered in a clinically appropriate manner and focused on the family's behavioral and functional outcomes as described in the discharge plan.
AND
 - There is documented active discharge planning.
3. Discharge Criteria
- The family has substantially met their treatment plan goals and objectives.
AND
 - The family has support systems secured to help them maintain stability in the community.
4. Clinical Best Practices
- Evaluation and Service Planning
 - An Initial Diagnostic Interview must be completed prior to the beginning of treatment.
 - Children should receive PCIT services only after a recent appropriate medical evaluation to rule out conditions of a general medical nature.
 - A goal-oriented treatment plan with measurable outcomes and a specific, realistic discharge plan must be developed with the member (identified patient) and the identified, appropriate family members as part of the initial assessment and outpatient family therapy treatment planning process.
 - The treatment and discharge plan must be evaluated and revised as medically indicated.
 - Assessment should be ongoing with treatment and reviewed each session.
 - Service Delivery
 - Services must be treatment focused and not rehabilitative or habilitative in nature.
 - There shall be a reasonable expectation that PCIT will improve the child's psychiatric symptoms so that the services will no longer be necessary.
 - Consultation and/or referral for general medical, psychiatric, psychological.
 - Provided as family psychotherapy.
 - It is the provider's responsibility to coordinate with other treating professionals as needed
 - The average length of service is typically 12-20 sessions and focused on changing negative parent/caregiver/child patterns as a result of an experienced trauma.
 - The goals of treatment are:
 - An improvement in the quality of the parent/child relationship or other caregiver relationships.
 - A decrease in child behavior problems with an increase in prosocial behaviors.
 - An increase in parenting skills, including positive discipline.
 - A decrease in parenting stress.
 - Discharge Planning
 - Length of treatment is individualized and based on clinical criteria for admission and continued treatment, as well as the member's ability to benefit from treatment.

PARTIAL HOSPITALIZATION

PARTIAL HOSPITALIZATION A Partial Hospital Program is a structured program that provides assessment and diagnostic services and active behavioral health treatment to members who are experiencing serious signs and symptoms that result in significant personal distress and/or significant psychosocial and environmental issues. The purpose of services is to stabilize and reduce acute signs and symptoms, increase functioning, and assist a member with integrating into community life. The course of treatment in a Partial Hospital Program is focused on addressing the factors that precipitated admission (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the member's condition can be safely, efficiently and effectively treated in a less intensive level of care.

A Partial Hospital Program can be used to treat mental health conditions or can specialize in the treatment of co-occurring mental health and substance-related disorders.

When supported by the benefit plan, coverage may be available for Partial Hospital Program services that coupled with overnight housing.

1. Admission Criteria

- The member is not in imminent or current risk or harm to self, others, and/or property.
AND
- Assessment and diagnosis and/or treatment planning requires observation and interaction for at least 20 hours per week. Examples include the following:
 - Assessment requires frequent interaction with the member, and observation of the member with others.
 - The treatment plan must be changed frequently which requires that the provider have face-to-face interactions with the member several times a week.
 - Services may be provided either half day (three hours a day, five days a week) or full day (six hours a day, five days a week).

OR

- The member requires engagement and support which requires extended interaction between the member and the program. Examples include the following:
 - The member requires a coordinated transition back into the community after treatment in Inpatient or a Residential Treatment Center, such as engagement with wraparound services or natural resources.
 - The member has been unable to access or utilize family or other natural resources on their own.

OR

- The member requires a structured environment to practice and enhance skills. This requires face-to-face interactions several times a week that cannot be provided in a less intensive setting. Examples of skills include those that help the member:
 - Maintain their current living situation;
 - Return to work or school.

OR

- The member requires a structured environment to complete goals and develop a plan for post-discharge services in a less intensive setting. Examples of assistance include the following:
 - Assistance with developing the skills needed to self-manage medications.
 - Assistance with making progress toward goals in spite of an environment that does not support recovery and/or limited community support services.

2. Clinical Best Practices

- Evaluation and Service Planning
 - The nursing assessment is completed within 24 hours of admission.
 - During admission, a psychiatrist is available to consult with the program during and after normal business hours.
 - A psychiatrist sees the member commensurate with the member's needs, with no less than weekly visits.
 - A treatment plan is completed within 10 business days of admission. The treatment plan will be individualized and will include the specific problems, behaviors, or skills to be addressed; clear and realistic goals and objectives; services, strategies, and methods of intervention to be implemented; criteria for achievement; target dates; methods for evaluating the individual's progress; and the responsible professional.
 - The individual treatment plan is reviewed at least every 30 days and more often as necessary, updated as medically indicated and signed by the supervising practitioner and other treatment team members, including the individual being served.

PEER SUPPORT SERVICES

PEER SUPPORT SERVICES: Peer support services are provided by members who have lived experience with Mental Health or Substance Use Disorders (SUD). The service is designed to assist members in initiating and maintaining the process of long-term recovery and resiliency to improve their quality of life, increase resiliency, health, and wellness by living self-directed lives and striving to reach their full potential. Peer support is person centered and supports dignity, self-advocacy, and empowerment. The core element of this service is the development of a relationship based on shared lived experience and mutuality between the provider and member. This service can be provided to Medicaid eligible members and their families in member and group settings.

Peer support services are based on the relationship between the Certified Peer Support Provider and the member. Activities of the peer support provider are to serve and support members through sharing their knowledge, beliefs and experiences that promote recovery and wellness are possible, and that the members being served have the ability to manage their behavioral health symptoms successfully;

Peer support services are provided in conjunction with one or more behavioral health services.

1. Admission Criteria
 - The member has been diagnosed with a DSM (current edition) mental health or substance use disorder; The member is exhibiting symptoms that necessitate and are likely to respond to behavioral health interventions including Peer Support; The member is enrolled in other active behavioral health interventions; The member is presenting with symptoms and/or functional deficits that interfere with his/her ability to aid in their own recovery; Peer Support Services are medically necessary as according to Nebraska Medicaid2; and If the member is a child, he/she meets the above criteria.
2. Continuing Stay Criteria
 - The member continues to meet admission criteria;
 - There is reasonable likelihood the member will substantially benefit from active continuation of Peer Support as demonstrated by objective measurable improvements;
 - The member is making progress toward goals and is actively participating in Peer Support interventions.

PSYCHIATRIC NURSING

PSYCHIATRIC NURSING The Psychiatric Registered Nurses or the Advanced Practitioner Registered Nurse offer primary care services to the mental health population in the primary residence of the member. The nurses assess, diagnose, and treat members with psychiatric disorders or the potential for such disorders using their full scope of therapeutic skills, including the prescription of medication and administration of psychotherapy.

The service is provided by a registered nurse (RN) or an Advanced Practitioner Registered Nurse (APRN) to members who are unable to access office-based services.

This service is available based on the member's medical condition, medical necessity, and appropriateness for the provision of services.

1. Admission Criteria
 - The member demonstrates symptomatology consistent with an active DSM diagnosis which will respond to therapeutic intervention and is a result of a mental illness.
AND
 - The member is receiving treatment services under a physician.
AND
 - Stabilization of the member's mental health condition requires psychiatric nursing.
AND
 - Psychiatric nursing will allow the member the best opportunity for stabilization of the mental health condition and is the least restrictive level of care for the member.
AND

- The treatment plan clearly identifies the types of services and interventions needed as a part of the mental health psychiatric health service...
2. Continued Service Criteria
 - The member continues to meet admission criteria.
AND
 - The member is maintaining stability of his/her mental health condition.
AND
 - The member is making progress as evidenced by improvement in the member's symptoms, problems and impairments.
AND
 - Psychiatric nursing care remains the least restrictive level of intervention for this member.
AND
 - The physician has evaluated the member's progress by review of the treatment plan and the progress every 60 days.
 3. Discharge Criteria
 - The member has established the necessary supports and there has been an increase the member's involvement with rehabilitation services in the community.
 4. Clinical Best Practices
 - Evaluation and Service Planning
 - The Initial Diagnostic Interview and additional nursing assessment, conducted by appropriate practitioners working within their scope of practice, will be completed prior to the initiation of services.
 - A physician's order is required to initiate this service.
 - The treatment plan must be individualized to the member and must include the specific problems, behaviors, or skills to be addressed; clear and realistic goals and objectives; services, strategies, and methods of intervention to be implemented; criteria for achievement; target dates; methods for evaluating the member's progress; and the responsible professional.
 - A reasonable discharge plan must be developed as part of the treatment plan that includes a plan for transitioning to a community based service.
 - The Treatment plan must be developed and reviewed every 60 days by the treatment team, the member, their family/significant others as appropriate, and the Supervising Practitioner. Updates/reviews of the plan must be signed by all of those involved in the review.
 - Service Delivery
 - Services may include medication administration, assistance in setting up a medication system, teaching and monitoring of medication, and observation of the physical well-being in relation to medication side effects.
 - This service is not intended to replace the direct involvement of a physician for the mental health treatment of the member.
 - Discharge Planning
 - The frequency and duration may vary based upon the needs of the member, but shall not exceed 35 days in the first 60-day authorization, and a maximum of 12 days for each subsequent 60-day authorization period.
 - The service must provide or otherwise demonstrate that members have on-call access to a mental health provider on a 24-hour, seven-day per week basis.

PSYCHIATRIC RESIDENTIAL REHABILITATION

PSYCHIATRIC RESIDENTIAL REHABILITATION Psychiatric Residential Rehabilitation is designed to provide individualized treatment and recovery inclusive of psychiatric rehabilitation and support for members with a severe and persistent mental illness and/or co- occurring disorder who are in need of recovery and rehabilitation activities within a residential setting. The intent of the service is to support the member in the recovery process so that he/she can be successful in a community living setting of his/her choice.

1. Admission Criteria

- DSM (current version) diagnosis consistent with a serious and persistent mental illness i.e. a primary diagnosis of a psychotic disorder, major affective disorder, or other major mental illness in the current edition of DSM.
AND
 - The persistent mental illness is 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 member's ability to function independently in an appropriate manner in two of three functional areas.
AND
 - The presence of functional deficits in two of the three following functional areas:
 - Vocational/Education: inability to be employed or an ability to be employed only with extensive supports; or 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; 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/others.
 - Activities of Daily Living: Inability to consistently perform the range of practical daily living tasks required 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.
 - AND
 - Functional deficits of such intensity requiring professional interventions in a 24 hour psychiatric residential setting.
AND
 - The member is at significant risk of continuing in a pattern of either institutionalization or living in a severely dysfunctional way if needed residential rehabilitation services are not provided.
AND
 - Requires 24-hour awake staff to assist with psychiatric rehabilitation.
2. Continued Service Criteria
- AND
- The member continues to meet admission criteria.
AND
 - The symptoms or behaviors demonstrated are based on the DSM diagnosis.
 - The member does not require a more intensive level of services and no less intensive level of care is appropriate.
AND
 - There is reasonable likelihood of substantial benefits as demonstrated by objective behavioral measurements of improvement in functional areas.
AND
 - The member is making progress towards rehabilitation goals.
AND
 - Continues to require 24-hour awake staff to assist with psychiatric rehabilitation.
3. Discharge Criteria
- The member has met their treatment/rehabilitation/recovery plan goals and objectives.
AND
 - The precipitating condition and relapse potential is stabilized such that the member's condition can be managed with professional external supports and interventions outside of the psychiatric residential rehabilitation facility.

AND

- The member has support systems secured to maintain stability in a less restrictive environment.
4. Clinical Best Practices
- Evaluation and Service Planning
 - A diagnostic interview conducted by a licensed, qualified clinician and credentialed mental health professional prior to admission OR completed within 12 months prior to the date of admission.
 - If the diagnostic interview was completed within 12 months prior to admission, a licensed, qualified clinician should review and update as necessary via an addendum, to ensure information is reflective of the member's current status and functioning. The review and update should be completed within 14 days of admission.
 - 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 member, should be completed within 30 days of admission and may be completed by non-licensed or licensed members on the member's team.
 - An initial treatment/rehabilitation/recovery plan (orientation, assessment schedule, etc.) to guide the first 14 days of treatment developed within 72 hours of admission.
 - Alcohol and drug screening assessment as needed.
 - A treatment/rehabilitation/recovery plan developed with the member, integrating member strengths & needs, considering community, family and other supports, stating measurable goals, that includes a documented discharge and relapse prevention plan completed within 30 days of admission.
 - A review the treatment/recovery and discharge plan with the member, other approved family/supports, and the Clinical Supervisor every 90 days or more often as needed; updated as medically indicated; approved and signed by the Clinical Supervisor, other team members, and the member being served.
 - Service Delivery
 - Psychiatric services are arranged as needed.
 - There is an ability to arrange for general medical, pharmacology, psychological, dietary, pastoral, emergency medical, recreation therapy, laboratory and other diagnostic and treatment services.
 - Ancillary service referral will be provided as needed: (dental, optometry, ophthalmology, other mental health and/or social services including substance use disorder treatment, etc.).
 - Therapeutic milieu offering 25 hours of staff led active treatment/rehabilitation/recovery activities per member available 7 days/week.
 - There is an on-site capacity to provide medication administration and/or self-administration, symptom management, nutritional support, social, vocational, and life-skills building activities, self-advocacy, peer support services, recreational activities, and other independent living skills that enable the member to reside in their community.
 - There is an ability to coordinate and offer a minimum of 20 hours/week of additional off-site rehabilitation, vocational, and educational activities.
 - There is an ability to coordinate other services the member may be receiving and refer to other necessary services.
 - Referral for services and supports to enhance independence in the community will be provided.
 - Discharge Planning
 - Length of service is individualized and based on clinical criteria for admission and continuing stay, as well as the member's ability to make progress on member treatment/recovery goals.

A PRTF is a facility provides inpatient psychiatric services to members under the age of 19. A PRTF must provide inpatient psychiatric services under the direction of a physician, must be accredited and must comply with all the requirements of applicable state and federal regulations.

PRTF is delivered to members who have functional impairments resulting from a behavioral health condition that has not responded to treatment in other community settings.

Specialized PRTF Programs:

- **Sexual Offender PRTF – The member has a sexual offense that has resulted in a legal charge or adjudication and a sex offender specific assessment has been conducted and the member has been determined to be at high risk to reoffend.**
- **Substance Use – The member is diagnosed with a Substance Use Disorder that meets ASAM level of care 3.7.**

1. Admission Criteria

- PRTF has been recommended by a team, including a physician, and the team has determined through evaluation and diagnosis that a physician supervised 24-hour residential/inpatient setting is the most clinically appropriate service.
 - Members determined to be appropriate for PRTF may not be disqualified from this level of care based solely on a diagnosis of borderline intellectual functioning or mild intellectual disability if it is determined that the member could participate in PRTF and benefit from treatment.

AND

- Alternative or less restrictive levels of care have not met the member's treatment needs:
 - Alternative or less restrictive levels of care have been attempted and were unsuccessful; or
 - Alternative or less restrictive levels of care were determined to not be appropriate to meet the member's needs.

AND

- The member's psychiatric condition requires 24-hour care under the direction of a physician as demonstrated by:
 - Severe and persistent symptoms and functional impairments consistent with a DSM, current edition, diagnosis that requires 24 hour residential psychiatric treatment under the direction of a physician.
 - The member's symptoms/severe functional impairment include at least one of the following:
 - Suicidal/homicidal ideation;
 - Substance Use Disorder that meets ASAM level of care 3.7;
 - Persistent or medically significant self-injurious behaviors;
 - A pattern of physical and verbal aggression due to a treatable behavioral health condition;
 - Significant eating disorder symptoms;
 - Severe mood instability;
 - Psychotic symptoms;
 - Sexually harmful behaviors

AND

- PRTF can reasonably be expected to improve the member's condition or prevent further regression so that the services will no longer be needed.

2. Continued Service Criteria

- All of the following are necessary for continuing treatment at this level of care:
 - The primary reason(s) the member met admission criteria continue to require ongoing treatment, or are replaced with other symptoms or functional impairments that meet admission criteria.

AND

- The services continue to be reasonably expected to improve the member's condition or prevent further regression so that the services will no longer be needed.

AND

- The active treatment plan includes intensive family interventions.
 - If this requirement cannot be met, the reasons must be reported, and efforts to involve family members continued. Under some circumstances an alternative plan, aimed at enhancing the member connection with other family members or supportive adults may be an appropriate substitute.
 - AND
 - A less restrictive level of care cannot yet meet the member's treatment needs.
 - AND
 - There is reasonable likelihood of substantial benefit to the member as demonstrated by objective behavioral measurements of improvement in functional areas.
3. Discharge Criteria
- Symptoms are stabilized and the member no longer meets clinical guidelines for PRTF level of care.
 - AND
 - The member has made substantial progress on his/her self-developed recovery plan goals and objectives, and developed a crisis relapse/prevention plan
 - AND
 - The member is able to be safely treated in the community
 - AND
 - Length of service is individualized and based on clinical criteria for admission and continuing stay, as well as the member's ability to make progress on member treatment/recovery goals.
4. Clinical Best Practices
- Service Delivery
 - Requires a certificate of need by an independent team that includes a physician.
 - The certificate of need must identify community resources do not meet the members need, the member requires inpatient services, and the services can be expected to improve the members condition or prevent further regression.
 - Inpatient psychiatric service must involve "active treatment" which means implementation of a professionally developed and supervised member plan of care, which is designed to achieve the member's discharge from inpatient status at the earliest possible time.
 - An Initial Diagnostic Interview (IDI) is completed prior to the beginning of treatment, and functions as the initial treatment plan until a comprehensive treatment plan is developed.
 - A treatment plan must be developed by an interdisciplinary team, the member, and their family/legal guardians within 14 days of admission. The treatment plan must be based off evaluations of the member's medical, psychological, social, behavioral and developmental needs. The treatment plan will identify objectives, the therapies/activities designed to meet those objectives and a discharge plan.
 - The discharge plan must identify the anticipated caregiver, what school the member will attend, recommendations for the IEP, outline the aftercare treatment plan, and identify potential barriers to the community reintegration and what has/is being done to address those barriers.
 - The treatment plan must be reviewed every 30 days by the team.
 - A PRTF member shall receive 40 hours of psychotherapy and other treatment interventions each week which include: individual, group and family psychotherapy/substance abuse counseling; OT/PT; speech; laboratory services; transportation; medical services as necessary; and nursing services available 24/7 (may be on call during sleep hours).
 - The following educational services must be provided for members with identified need in these areas: crisis intervention; life skills; social skills; substance abuse; self-care; medication; health care (nutrition, hygiene and personal wellness); vocational planning; and recreational activities.

- Use of restraint and seclusion will be in compliance with federal standards and facility licensing requirements.
- Facilities will be in compliance with CFR title 42; Chapter IV; Subchapter G; Part 483; Subpart G regarding use of restraint or seclusion in Psychiatric Residential Treatment Facilities providing individual psychiatric services for member under Age 21.
- Discharge Planning
 - Length of service is individualized and based on clinical criteria for admission and continued stay, as well as the member's ability to make progress on member treatment/recovery goals.

RISK ASSESSMENT FOR YOUTH WHO SEXUALLY HARM

RISK ASSESSMENT FOR YOUTH WHO SEXUALLY HARM Children and Adolescents

The purpose of the risk assessment is to identify how mental health/substance use disorder diagnoses relate to sexually harmful behavior and to provide a risk assessment to develop treatment recommendations, if indicated. This is not a forensic evaluation, but is intended to guide treatment.

1. Admission Criteria

- The recommendation for this specialized risk assessment is being made by a clinician with specific expertise and training in assessing members with sexually harmful behavior, and is being made only after a full review of documented evidence of the member's sexually harmful behavior or after a completing a face-to-face assessment of the member and a determination has been made that the member's presenting problems cannot be adequately assessed through the use of other assessments such as an Initial Diagnostic Interview or standardized psychological testing.
- There is an age and/or developmental differential between the alleged perpetrator/member and victim or non-consensual sexual contact with a peer of similar age and/or developmental ability is alleged.
AND
- The behaviors are assaultive in nature and 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 member from being able to adequately function in the home, school and/or community or complete activities of daily living.
AND
- The member is involved and capable of participating in the risk assessment.
AND
- The member is 20 years old or younger.
AND
- Referral for a risk assessment must be accompanied by court adjudication, police reports, investigation summaries or other official reports or evidence of sexually harmful behavior.

2. Discharge Criteria

- The member will receive a comprehensive assessment that includes information on the risk for re-offending, mental health and substance use disorders.

3. Clinical Best Practices

- Evaluation and Service Planning
 - This is a service provided for member aged 20 or younger.
 - The need for this assessment is based on medical necessity as determined by a licensed clinical psychologist or psychiatrist upon completion of an Initial Diagnostic Interview.
 - The practitioner completing the assessment will collaborate and disseminate the assessment results with other professionals involved.
 - The components for a sexual offender risk assessment include:
 - Demographic: the reason for the assessment (police, IDI and court records); interviews with family, member and other relevant contacts; review of previous assessments/testing.

- Biopsychosocial: family dynamics/relations; member background information i.e. social, school, legal, mental health, substance abuse, sexual offense history, trauma/victimization history, and personal strengths.
- Psychological evaluation: cognitive/adaptive functioning, behavior, personality measures; use of risk assessment instruments measuring both dynamic and static factors (i.e., ERASOR-2, ASO Questionnaire, Juvenile Risk Assessment Scale).
- Treatment recommendations which will include an assessment of the risk for reoffending.
- Addendums to the risk assessment are appropriate when the member has had a subsequent offense and the assessing provider had completed a full risk assessment previously. In these cases, the provider must conduct an updated risk assessment and also update other pertinent information contained in the original/prior assessment(s). The original risk assessment must be attached to the addendum in order to provide a complete clinical assessment.
- The cost for psychological testing is included in the reimbursement and may not be billed separately.
- Discharge Planning
 - One assessment is the length of this service.

SECURE PSYCHIATRIC RESIDENTIAL

SECURE PSYCHIATRIC RESIDENTIAL Secure Residential Treatment is intended to provide individualized recovery, psychiatric rehabilitation, and support as determined by a strengths-based assessment for members with a mental illness and/or co-occurring substance use disorder demonstrating a high-risk for harm to self/others and in need of a secure, recovery/rehabilitative/therapeutic environment.

1. Admission Criteria

- The member must meet ONE of the following criteria:
 - There is a high risk of relapse or symptom reoccurrence, as evidenced by the following (must meet ALL criteria):
 - Active symptomology consistent with DSM diagnoses, and
 - High need for professional structure, intervention and observation, and
 - High risk for re-hospitalization without 24-hour supervision, and
 - Unable to safely reside in less restrictive residential setting without 24-hour supervision.
 - OR
 - There is a high risk of danger to self as a result of symptoms related to the principal DSM diagnosis, as evidenced by any of the following:
 - There have been life threatening/disabling attempts of self-harm and a continued risk of self-harm without 24-hour behavioral monitoring.
 - Suicidal ideation.
 - A level of suicidality that cannot be safely managed without 24-hour behavioral monitoring.
 - Risk of severe self-neglect resulting in harm or injury.
 - OR
 - There is a high risk of danger to others, as a result of the symptoms related to a principal DSM diagnosis, as evidenced by any of the following:
 - Life threatening behavior and continued risk without 24-hour behavioral supervision and intervention.
 - Harmful ideation.

2. Continued Service Criteria

- There is a valid DSM diagnosis or co-occurring disorder that results in a pervasive level of impairment.
- AND
- There is a reasonable likelihood of benefit as a result of recovery/rehabilitation therapeutic activities that necessitates the 24-hour secure care setting.
- AND
- The member is able to participate in recovery/rehabilitation/therapeutic activities.

- AND
 - The member is making progress towards recovery goals.
 - AND
 - That symptoms or behaviors demonstrated are based on the DSM Diagnosis as a result of a mental illness.
 - AND
 - A less intensive level of care and supervision would be insufficient to safely support the member.
3. Discharge Criteria
- Symptoms are stabilized and the member no longer meets clinical guidelines for secure residential care.
 - AND
 - The member has made progress on his/her self-developed recovery plan goals and objectives, and developed a crisis relapse/prevention plan.
 - AND
 - The member is able to be safely treated in the community.
4. Clinical Best Practices
- Evaluation and Service Planning
 - There is a completed history and physical examination within 24 hours of admission by a physician or APRN.
 - A history and physical may be accepted from previous provider if completed within the last three months.
 - An annual physical must be completed.
 - The Initial Diagnostic Interview is completed within 24 hours of admission by a psychiatrist.
 - The nursing assessment is completed within 24 hours of admission.
 - Other assessments are completed as needed, and as needed on an ongoing basis all of which should integrate mental health and substance use disorder treatment needs.
 - The initial treatment/recovery plan is completed within 24 hours of admission with the psychiatrist as the supervisor of clinical treatment and direction.
 - The multidisciplinary bio-psychosocial assessment is completed within 14 days of admission.
 - A member recovery/discharge/relapse prevention plan is developed with the member and chosen supports (with informed consent) within 30 days of admission and reviewed weekly by the member and recovery team.
 - There is an integration of substance use disorder and mental health needs and strengths in assessment, treatment/recovery plan, and programming.
 - Service Delivery
 - Consultation services are available for general medical, dental, pharmacology, psychological, dietary, pastoral, emergency medical, recreation therapy, laboratory and other diagnostic services as needed.
 - There are face-to-face contacts with a psychiatrist at a minimum of every 30 days or as often as medically necessary.
 - There are 42 hours of active treatment available/provided to each member weekly, seven days per week.
 - There is access to community-based rehabilitation/social services to assist in transition to community living.
 - Medication management (administration and self-administration), and education is available.
 - Psychiatric and nursing services are available.
 - Member, group, and family therapy and substance use disorder treatment as appropriate are available.
 - Psycho-educational services including daily living, social skills, community living, family education, transportation to community services, peer support services, advance directive planning, self-advocacy, recreation, vocational and financial are provided.
 - Discharge Planning

- Length of service is individualized and based on clinical criteria for admission and continuing stay, as well as the member's ability to make progress on treatment/recovery goals. A member may decline continuation of the service, unless under mental health board commitment, court order, or at the direction of their legal guardian.

SUBACUTE INPATIENT TREATMENT

SUBACUTE INPATIENT Subacute services are provided in a psychiatric hospital or general hospital with a psychiatric unit. The purpose of subacute care is to provide stabilization, engage the member in comprehensive treatment, rehabilitation and recovery activities, and transition the member to the least restrictive setting as rapidly as possible.

1. Admission Criteria
 - The individual meets medical necessity for evaluation, stabilization, and treatment services.
AND
 - The member is high risk to harm self/others.
AND
 - The member has active symptomatology consistent with the current version of the American Psychiatric Association's Diagnostic and Statistical Manual (current edition) diagnoses.
AND
 - The member has a high need for and the ability to respond to intensive structured intervention services.
AND
 - The member is at high risk of relapse or symptom reoccurrence.
2. Continued Service Criteria
 - The member must continue to meet the admission criteria identified above.
AND
 - Continuation of symptoms or behaviors that required admission, and the judgment that a less intensive level of care and supervision would be insufficient to safely support the member.
AND
 - The member has not reached treatment goals but continues to show progress and willingness to work toward achievement of treatment goals.
3. Discharge Criteria
 - Symptoms are stabilized and the member no longer meets clinical guidelines for acute care.
AND
 - Sufficient supports are in place and the member can move to a less restrictive environment.
AND
 - Treatment plan goals and objectives are substantially met.
4. Clinical Best Practices
 - Evaluation and Service Planning
 - The following assessments must be conducted: Initial Diagnostic Interview (IDI), nursing assessments, laboratory, radiological, substance use disorder; physical and neurological exams and other diagnostic tests as necessary. Some of the required assessments may be covered under the medical benefit.
 - Family members are encouraged to participate in the assessment/treatment of the member as appropriate and approved by the member and their participation or lack of participation is documented in the member's record.
 - A treatment plan is designed and implemented to address the needs identified by the assessments. The treatment plan must include a specific, realistic and individualized discharge plan. The treatment plan must be reviewed three (3) times a week.
 - Service Delivery
 - Flexible meetings are scheduled to include evenings and weekends to facilitate family participation.

- An intensive and comprehensive active treatment program that includes professional psychiatric, medical, surgical, nursing, social work, psychological, and activity therapies required to carry out a member treatment plan for each patient and their family is provided.
- The member receives face to face evaluation and treatment by a psychiatrist three times a week or more often as necessary.
- Psychiatric nursing interventions are available to patients 24/7.
- Qualified staff are available to provide treatment intervention, social interaction and experiences, education regarding psychiatric issues such as medication management, nutrition, signs and symptoms of illness, substance abuse education, recovery, appropriate nursing interventions and structured milieu therapy.
- Available services must include member, group, and family therapy, group living experiences, occupational and recreational therapy and other prescribed activities to maintain or increase the member's capacity to manage his/her psychiatric condition and activities of daily living.
- Medication management services are provided for the provision and monitoring of psychotropic medications.
- Member, group, and family therapy available are offered as tolerated and/or appropriate.
- Social Services engage in discharge planning and help the member develop community supports and resources and consult with community agencies on behalf of the member.
- Discharge Planning
 - Medical necessity for a member to remain at this level of care determines length of service.

TESTING GUIDELINES

PSYCHOLOGICAL AND NEUROPSYCHOLOGICAL TESTING Please apply the below NE service definition and apply with the American Psychological Association Guidelines for Psychological and Neurological Testing.

Psychological testing involves the culturally and linguistically competent administration and interpretation of standardized tests to assess an individual's psychological or cognitive functioning.

Prior to testing, the client must be assessed by a licensed psychologist using best practices and a standard model of care.

- Psychological testing is considered when a diagnostic interview and behavioral observations are not able to differentially diagnose.
- Requests for psychological testing should 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.
- Testing may also be viewed as a potentially helpful second opinion for treatment strategies and/or difficult to diagnose cases.
- Requested tests must be standardized, valid and reliable.
- The instrument must be age, developmentally, linguistically and culturally appropriate to the client.
- Testing requests must meet medical necessity criteria.
- The time per test will be a maximum of one and one-half the time the standard time it takes to administer the test.
- The service is inclusive of the administration, observation, scoring, interpretation and report writing.
- Results of psychological testing must include the following:
 - demographic information,
 - dates of services,
 - the presenting problem,
 - results of the testing,
 - interpretation and explanation of the validity of the results,

- Diagnostic recommendations derived from the testing.

THERAPEUTIC GROUP HOME

THERAPEUTIC GROUP HOME Therapeutic Group Homes deliver an array of clinical, treatment and related services, including psychiatric supports, integration with community resources and skill-building taught within the context of a home-like setting.

Treatment is focused on reducing the severity of the behavioral health issues that were identified as the reasons for admission. Most often, targeted behaviors relate directly to the member's ability to function successfully in the home and school environments (e.g., compliance with reasonable behavioral expectations, safe behavior and appropriate responses to social cues and conflicts).

1. Admission Criteria

- The member's behavioral health condition can only be safely and effectively treated in a 24 hour therapeutic milieu with onsite behavioral health therapy due to significant impairments in home, school and community functioning caused by current mental health symptoms consistent with the DSM-5 diagnosis.
AND
- Less restrictive community based services were unable to meet the member's needs as indicated by documentation of one of the following:
 - Less restrictive services have been given a fully adequate trial, and were unsuccessful or,
 - Less restrictive services were considered, but not attempted as they were not clinically appropriate.
- The member doesn't require a more intensive level of care.
AND
- The member doesn't require primary medical or surgical treatment.
AND
- Therapeutic Group Home 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 member.
AND
- Therapeutic Group Home must not be utilized for clinically inappropriate reasons such as:
 - 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 member exhibiting primarily delinquent or antisocial behavior, or
 - The equivalent of safe housing or permanency placement, or
 - An alternative to parents', guardian's or agency's capacity to provide a place of residence for the member, or
 - A treatment intervention, when other less restrictive alternatives are available.
AND
- The member's treatment goals are included in the pre-admission psychiatric or psychological evaluation and include behaviorally defined objectives that require, and can reasonably be achieved within a Therapeutic Group Home setting.
- Therapeutic Group Home is medically necessary².

2. Continued Service Criteria

² ² The need for treatment services which are necessary to diagnose, treat, cure or prevent regression of significant functional impairments resulting from symptoms of a mental health or substance use disorder diagnosis.

Treatment services shall:

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

- All of the following are necessary for continuing treatment at this level of care:
 - All of the admission criteria continue to be met and this is supported by the written clinical documentation.

AND

- There is a written, up-to-date Discharge Plan that:
 - Identifies the custodial parent or custodial caregiver at discharge,
 - Identifies the school the member will attend at discharge,
 - Includes IEP recommendations, if necessary,
 - Outlines the aftercare treatment plan (discharge to another residential LOC is not an acceptable discharge goal), and
 - Lists barriers to community reintegration, and progress made on resolving these barriers since last review.

AND

- The member is demonstrating progress in treatment and/or there is clinical evidence that continued Therapeutic Group Home services can reasonably be expected to improve the member's symptoms, so that Therapeutic Group Home services will no longer be necessary.

AND

- The Active Treatment Plan includes:
 - Intensive family interventions with a frequency of one family therapy session per week, although twice per month is minimally acceptable.
 - Family involvement begins immediately upon admission. If the minimum requirement cannot be met, the reasons must be reported, and continued efforts to involve family members must also be documented.
 - Under certain circumstances an alternate plan, aimed at enhancing the member's connections with other family members and/or supportive adults may be an appropriate substitute.

AND

Less restrictive treatment options have been considered, but cannot yet meet the member's treatment needs. There is sufficient current clinical information to show that Therapeutic Group Home continues to be the least restrictive level of care that can meet the member's mental health treatment needs.

3. Discharge Criteria

- The member has met his/her treatment plan goals and objectives.

AND

- Discharge planning begins upon admission, with concrete plans for the member to transition back into the community beginning within the first week of admission, with clear action steps and target dates outlined in the treatment plan.

AND

- Length of service is individualized and based on clinical criteria for admission and continuing stay. The duration of the stay varies according to the member needs of the member and the member's response to the day-to-day treatment intervention.

4. Clinical Best Practices

- An Initial Diagnostic Assessment (IDI) Assessment must have documented evidence of the need for Therapeutic Group Home prior to treatment. The Physician or a Psychologist must be the referring clinician as well as the member that signs off on the application for placement.
- A treatment plan is completed within 7 days of admission. The treatment plan is individualized and must include the specific problems, behaviors, or skills to be addressed; clear and realistic goals and objectives; services, strategies, and methods of intervention to be implemented; criteria for achievement; target dates; methods for evaluating the member's progress; and the name of the responsible professional.
- The treatment plan is reviewed at least every 14 days or more as necessary, updated as medically indicated and signed by the supervising provider and other treatment team members including the member and/or their legal guardian.
- Parental/caregiver involvement in treatment is essential and evidence based and includes parents/caregivers in therapy as the expectation of treatment.

- i. Unless otherwise prohibited, providers shall involve the family in assessment, treatment planning and updating of the treatment plan, therapy and transition/discharge planning.
- Service Delivery
 - The program has formal arrangements for access to:
 - Nursing care (24 hours per day)
 - Psychological services
 - Pharmacy services
 - Dietary services
 - The program incorporates research-based, trauma-informed programming and training.
 - Focus is on:
 1. Reducing the behavior and symptoms of the mental health and/or substance use disorder that necessitated the removal of the member from his or her usual living situation.
 2. Increase developmentally appropriate, normative and pro-social behavior in members who are in need of out-of-home treatment.
 3. Transition members from Therapeutic Group Homes to home, or community-based living with outpatient treatment (e.g., member and/or family therapy).
 - The Therapeutic Group Home must provide 21 hours of active and rehabilitation treatment that will include, but not be limited to:
 1. Three hours of weekly individual Psychotherapy, Substance Use Disorder Counseling and/or Group Psychotherapy and/or Substance Use Disorder Counseling
 2. Twice monthly Family Psychotherapy and/or Family Substance Use Disorder Counseling
 3. Psycho-educational groups and member psycho-educational therapy services may include, but are not limited to:
 - Crisis intervention plan and aftercare planning
 - Social skills building
 - Life survival skills
 - Substance use disorder prevention intervention
 - Self-care services
 - Recreational activity
 - Medication education and medication compliance groups
 - Health care issues group (may include nutrition, hygiene and personal wellness).
- Discharge Planning
 - Discharge planning begins upon admission, with concrete plans for the member to transition back into the community beginning within the first week of admission, with clear action steps and target dates outlined in the treatment plan.
 - Length of service is individualized and based on clinical criteria for admission and continuing stay. The duration of the stay varies according to the member needs of the member and the member's response to the day-to-day treatment intervention.
 - The program coordinates with the member's community resources, including schools, with the goal of transitioning the member out of the program to a less restrictive care setting for continued, sometimes intensive, services as soon as possible and appropriate.

REFERENCES

Nebraska Administrative Code, Title 206: Behavioral Health Services and Utilization Guidelines. January, 2016.

Nebraska Department of Health and Human Services, Psychiatric Services, Administrative Code, 471-Chapter 20, retrieved from www.sos.ne.gov/rules-and-regs/.

Nebraska Department of Health and Human Services, Psychiatric Services for Members 21 and Older, Administrative Code, 471-Chapter 20, retrieved from www.sos.ne.gov/rules-and-regs/.

Nebraska Department of Health and Human Services, Psychiatric Services for Members 21 and Older, Administrative Code, 471-Chapter 20 and Chapter 32, retrieved from www.sos.ne.gov/rules-and-regs/.

Nebraska Department of Health and Human Services, Administrative Code, 471-Chapter 32, retrieved from www.sos.ne.gov/rules-and-regs/.

Nebraska Administrative Code, Title 471, Chapter 32, Children’s Mental Health and Substance Use Treatment Services. June, 2013. Retrieved from www.sos.ne.gov/rules-and-regs/.

Nebraska Department of Health and Human Services, Psychiatric Services, Administrative Code, 471-Chapter 20/32/35, retrieved from www.sos.ne.gov/rules-and-regs/.

Nebraska Administrative Code, Title 471, Chapter 20, 32 and 35, Rehabilitative Psychiatric Services. October, 2015. Retrieved from www.sos.ne.gov/rules-and-regs/.

Nebraska Department of Health and Human Services, Psychiatric Services for Members 21 and Older, Administrative Code, 471-Chapter 35, retrieved from www.sos.ne.gov/rules-and-regs/.

Nebraska Administrative Code, Title 471, Chapter 35, Rehabilitative Psychiatric Services. October, 2015. Retrieved from www.sos.ne.gov/rules-and-regs/.

REVISION HISTORY

Date	Action/Description
01/2017	• Version 1
09/2018	• Version 2
01/31/2020	• Version 3; Annual review
01/01/2021	• Version 4: Annual review. Added information regarding American Psychological Association Guidelines for Psychological and Neuropsychological Testing.
11/2022	• Version 5: Annual Review

ⁱ 471 NAC 1-002.02A Medical Necessity: Health care services and supplies which are medically appropriate and -

1. Necessary to meet the basic health needs of the member;
2. Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service;
3. Consistent in type, frequency, duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies;
4. Consistent with the diagnosis of the condition;
5. Required for means other than convenience of the member or his or her physician;
6. No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
7. Of demonstrated value; and
8. No more intense level of service than can be safely provided.