General Introduction

The Nebraska Medicaid Program covers medically necessary treatment services for conditions diagnosed in youth age 20 and younger during an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Health Check) examination. Treatment coverage includes mental health and substance abuse conditions.

History

Federal - State Medical Assistance Programs are administered in accordance with Federal requirements of Title XIX of the Social Security Act. Medical Assistance Programs (MAP) (also known as Medicaid) are administered under the Centers for Medicare and Medicaid Services (CMS) who approve each state's plan. The approved state plan is the basis for determining Federal Financial Participation in the state program.

State - The Nebraska Medical Assistance Program (NMAP) (also known as Nebraska Medicaid) was established under Title XIX of the Social Security Act and is administered statewide by Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care. Medical and health-related services are provided to eligible persons who do not have resources and income to meet medical needs. Among the benefits provided to eligible Medicaid participants are mental health and substance abuse services. These services are identified in Chapter 32 of the Nebraska Medical Assistance Program for individuals age 20 and younger.

Nebraska Medicaid Managed Care Program (NMMCP) - In July, 1995, Nebraska Medicaid obtained a waiver from the Centers for Medicare and Medicaid Services (CMS) and implemented the Nebraska Medicaid Managed Care Program (NMMCP). Mental health and substance abuse services are a benefit under the managed care program for eligible clients. Service descriptions and guidelines for admission, exclusion, continued stay, and discharge for mental health/substance abuse levels of care are found in the Nebraska Medicaid Managed Care Handbook Supplement, Appendix B.

Placement Criteria – On September 1, 2008, Medicaid introduced the application of the American Society of Addiction Medicine (ASAM) Patient Placement Criteria for the treatment of substance-related disorders with Medicaid eligible clients age 20 and younger. The adoption of placement criteria is a means of assuring the most appropriate level of substance abuse treatment services for client's individualized needs. Nebraska Medicaid has identified the ASAM service placement definitions as appropriate for Nebraska Medicaid levels of care. The levels are as follows:

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Please see the following subchapter for additional, more specific information regarding Medicaid mental health/substance abuse treatment levels of care identified in the Nebraska Medical Assistance Program, Chapter 32 (471 NAC 32-000).

(8-1-08)
INITIAL ADOLESCENT SUBSTANCE ABUSE ASSESSMENT

For Nebraska Medicaid Enrolled Providers of Mental Health/Substance Abuse Treatment Services, this assessment may be completed in lieu of the biopsychosocial assessment Part I of Pretreatment Assessment (PTA) identified in Chapter 32 of the Nebraska Medical Assistance Program (NMAP). This assessment in addition to the initial diagnostic interview provided by a practitioner of the Healing Arts (psychologist or psychiatrist) will serve as a comprehensive Pretreatment Assessment (includes Part I and II of the PTA) for mental health and substance abuse problems.

The following is based on the Adolescent Criteria of the Patient Placement Criteria for the Treatment of Substance-Related Disorders. Providers will use the American Society of Addiction Medicine, Second Edition Revised (ASAM PPC-2R or current version). Providers are responsible to refer to the ASAM PPC-2R ADOLESCENT PLACEMENT MANUAL for the complete criteria.

The Initial Adolescent Substance Abuse Assessment must be completed in an appropriately licensed Nebraska Substance Abuse Treatment Center by a clinician licensed as follows:
Substance Abuse Assessment – LADC, LIMHP, LMHP, LMHP/LADC, LMHP/PLADC, Psychologist
Dual Assessment (SA/MH) - LMHP, LIMHP, LMHP/LADC, LMHP/PLADC, Psychologist

The Report is comprised of three components:

I. SCREENING INSTRUMENTS AND SCORES
II. COMPREHENSIVE BIOPSYCHOSOCIAL ASSESSMENT AND INITIAL DIAGNOSTIC INTERVIEW
III. MULTIDIMENSIONAL RISK PROFILE TO DETERMINE TYPE AND INTENSITY OF SERVICES

I. SCREENING INSTRUMENTS AND SCORES:
All Initial Adolescent Substance Abuse Assessment Reports must include the use and results of at least one of the following nationally accepted screening instruments. The instruments may be electronically scored if indicated acceptable by author:
• SASSI (Substance Abuse Subtle Screening Inventory)
• TII (Treatment Intervention Inventory)
• SUDDS (Substance Use Disorder Diagnostic Schedule)
• MADIS (Michigan Alcohol Drug Inventory Screen)
• MAST (Michigan Alcoholism Screening Test)
• MINI (MiniInternational Neuropsychiatric Interview)
• WPI (Western Personality Interview)
• PBI (Problem Behavior Inventory)
• RAATE (Recovery Attitude and Treatment Evaluator)
• CIWA (Clinical Institute Withdrawal Assessment)

II. COMPREHENSIVE BIOPSYCHOSOCIAL ASSESSMENT/SUBSTANCE ABUSE EVALUATION:
(The completed Comprehensive Adolescent Severity Inventory (CASI) document must be equivalent to a comprehensive biopsychosocial assessment. Providers must use the "Comments" area in each section to further complete and specifically describe clinical information when checklists and inventories are not adequate.)
The Comprehensive Adolescent Severity Inventory (CASI) is required to be used in a face-to-face structured interview. The CASI is to be scored and utilized to provide information to the supervising practitioner (psychologist or psychiatrist) who completes the initial diagnostic interview and the multi-risk profile.

The biopsychosocial assessment/substance abuse evaluation will include all of the following:

A. **DEMOGRAPHICS**
   1. **Face Sheet**
      Complete 1-18 as well as "reason for intake," "insurance information," "disability," "known to foster care," "known to juvenile/criminal justice, and other agencies."
   2. **General Information**
      Complete 1-18 as well as "Comments."
   3. **Legal Guardians**
   4. **Other Involved Adults**

B. **HEALTH INFORMATION**
   1. **Medical symptoms, problems and diagnoses**
   2. **Prescribed medications and medication information (daily as well as "as necessary" medications)**
   3. **Last physical or last appointment by medical physician**
   4. **Comments (specific information is necessary)**

C. **STRESSFUL LIFE EVENTS**
   Complete 1-14 and "Comments"

D. **EDUCATION**
   **Section I**
   Complete 1-24 and "Comments"
   **Section II**
   Complete 1-26 and "Comments"

E. **DRUG/ALCOHOL USE**
   Complete 1-11 and "Comments"
   Complete 12-18 and "Comments"
   Complete 19-30
   Complete 31-35 and "Comments"
   Complete 36-45 and "Comments"

F. **USE OF FREE TIME**
   1. **Section I - Employment**
      Complete 1-13 and "Comments"
   2. **Section II**
      Completed only if the youth is not currently enrolled or attending school
      Complete 14-17 and "Comments"
   3. **Section III - Leisure Activity**
      Complete 18-37 and "Comments"

G. **PEER RELATIONSHIPS**
   Complete 1-13 and "Comments"
   Complete 14-26 and "Comments"
III. MULTIDIMENSIONAL RISK PROFILE

Recommendations for individualized treatment, potential services, modalities, resources, and interventions must be based on the ASAM national criteria multidimensional risk profile. Below is a brief overview on how to use the matrix to match the risk profile with type and intensity of service needs. The provider is responsible for referring to ASAM PPC-2R for the full matrix when applying the risk profile for recommendations.

Step 1: Assess all six dimensions to determine whether the patient has immediate needs related to imminent danger, as indicated by a Risk Rating of “4” in any of the six dimensions. The Dimensions with the highest risk rating determines the immediate service needs and placement decision.

Step 2: If the patient is not in imminent danger, determine the patient’s Risk Rating in each of the six dimensions. (For patients who have “dual diagnosis” problems, assess Dimensions 4, 5 and 6 separately for the mental and substance-related disorders. This
assists in identifying differential mental health and addiction treatment service needs and helps determine the kind of dual diagnosis program most likely to meet the patient’s needs.)

**Step 3:** Identify the appropriate types of services and modalities needed for all dimensions with any clinically significant risk ratings. Not all dimensions may have sufficient severity to warrant service needs at the time of the assessment.

**Step 4:** Use the Multidimensional Risk Profile produced by this assessment in Steps 2 and 3 to develop an initial treatment plan and placement recommendation. This is achieved by identifying in which level of care the variety of service needs in all relevant dimensions can effectively and efficiently be provided. The appropriate Intensity of Service, Level of Care and Setting may be the highest Risk Rating across all the dimensions. Consider, however, that the interaction of needs across all dimensions may require more intensive services than the highest Risk Rating alone.

**Step 5:** Make ongoing decisions about the patient’s continued service needs and placement by repeating Steps 1 through 4. Keep in mind that movement into and through the continuum of care should be a fluid and flexible processes that is driven by continuous monitoring of the patient’s changing Multidimensional Risk Profile.

(8-1-08)
OUTPATIENT SUBSTANCE ABUSE TREATMENT (ASAM LEVEL I: OUTPATIENT TREATMENT)

For Nebraska Medicaid Enrolled Providers, this subchapter applies to traditional outpatient services for providers who are credentialed by the Nebraska Medicaid Managed Care Program (NMMCP). Providers will adhere to the regulations and program descriptions of the Nebraska Medical Assistance Program (NMAP) Chapter 32 (471 NAC 32-001 Outpatient Services) and the Medicaid managed care service description for traditional outpatient services as described in the Medicaid Managed Care Handbook Supplement, Appendix B.

- The following is based on the Adolescent Criteria of the Patient Placement Criteria for the Treatment of Substance-Related Disorders of the American Society of Addiction Medicine, Second Edition Revised (ASAM PPC-2R or current version) pages 209-219. Providers are responsible to refer to the ASAM PPC-2R Adolescent Placement Manual for complete criteria.

SERVICES: Level I services are organized outpatient treatment services which may be delivered in a variety of appropriate settings, such as outpatient hospitals, clinics, and mental health centers. In Level I programs, addiction treatment staff, provide professionally directed evaluations, treatment and recovery services to adolescents who have substance-related disorders. Services are tailored, as clinically indicated, to each youth's level of clinical severity and are designed to assist the youth to achieve permanent change in his or her alcohol or other drug using behaviors. Treatment must address major familial, attitudinal, behavioral and cognitive issues that have a potential to undermine the goals of treatment or impair the adolescent's ability to cope with major life tasks. Treatment interventions and modalities are tailored to address the levels of developmental maturity.

Treatment at this level of care may require coordination with other services such as additional psychiatric assessment and treatment, medical assessment and treatment, educational testing, juvenile justice probation, foster care, and/or human services.

Level I services can be appropriate in the following situations:
- As an initial level of care when the severity of illness warrants this intensity of intervention. Treatment should be able to be completed at this level, thus using only one level of care unless unanticipated events warrant reassessment of the appropriateness of alternative levels of care or reoccurring evidence that the adolescent is unable to use this level of care. An example is repeated episodes of usage, even after the treatment plan is reviewed and revised.
- As a step-down program from higher more restrictive levels of treatment and care.
- As an alternative approach to engage a resistant youth in treatment who has early stages of readiness but not ready to commit to full recovery. While an adolescent may require a more intensive level of care to address high levels of resistance and denial, an increased intensity can be counterproductive in certain situations. Less intensive levels of care may be used to engage the resistant youth.

DETOXIFICATION SERVICES: Providers are referred to Level IV Acute Inpatient Hospital Detoxification Services (med-surg) for medically managed intensive inpatient detoxification services.

SETTING/HOURS: Individual, group and family therapy are provided in regularly scheduled sessions in a clinic, office or outpatient hospital. If substance abuse licensure is required for the clinic, agency or facility, the provider must obtain this license. Providers should have direct affiliation with more or less intensive levels of care and hours should coincide to meet the needs of the adolescents and parents' daily schedule. Emergency services are available 24 hours per day and seven days per week.
STAFFING: Staffing consists of appropriately licensed treatment professionals including psychiatrists, psychologists, and other appropriate licensed clinicians who are able to assess and treat substance and mental health related disorders. Fully licensed clinicians must be able to assess the patient's biopsychosocial needs, be knowledgeable about the biopsychosocial dimensions of alcohol and other drug disorders and mental health disorders and assess the youth's readiness to change. Clinicians are knowledgeable about adolescent development and experienced in working and engaging adolescents in treatment. Licensed clinicians must be capable of monitoring stabilized mental health disorders and recognizing any instability of patients with co-occurring mental health concerns, provide appropriate treatment and, when necessary, make appropriate referrals.

THERAPIES: Therapies offered in Level I may include individual, family, and group counseling, psychotherapy, cognitive/behavioral modification, motivational enhancement, and other therapies in conjunction with a rehabilitation plan. Motivational enhancement and engagement strategies are used in preference to confrontational approaches. Mental health issues, psychotropic medication concerns and their relationship to substance use disorders must be addressed as they arise. Use of medically necessary laboratory services should be available through consultation or referral. (Providers must access laboratory services from an enrolled Medicaid laboratory.) Maintenance strategies such as relapse prevention and strengthening protective factors are crucial components of treatment.

ASSESSMENT/TREATMENT PLAN: A comprehensive biopsychosocial assessment is a part of the pretreatment assessment to determine mental health and/or substance abuse issues (471 NAC 32-001). However, the Comprehensive Adolescent Severity Inventory (CASI) may be completed in lieu of Part I of the pretreatment assessment (471 NAC 32-001 Biopsychosocial Assessment) regulation, when symptoms include substance abuse or substance dependence as a primary condition. Either assessment format must be followed by an Initial Diagnostic Interview provided by a Licensed Practitioner of the Healing Arts (psychiatrist or psychologist). The individualized treatment plan and treatment plan reviews which involve problem formulation and articulation of measurable treatment goals and activities are designed to achieve treatment goals. The plan is developed in collaboration with the youth and the youth's guardian/family/caregiver and reflects the youth's personal goals. The initial individualized treatment plan must be developed within two weeks following the completion of the pretreatment assessment (Part I and II). Assessment of its clinical appropriateness is completed with regular reviews every 30 days thereafter.

LENGTH OF STAY: Individualized, according to the severity of illness and the youth's response to treatment.

DOCUMENTATION: Documentation requirements for Level I programs include:
- A comprehensive biopsychosocial assessment;
- An Initial Diagnostic Interview by the psychiatrist or psychologist;
- Master treatment plan and updated plans;
- Individual progress notes clearly reflecting the implementation of the treatment plan;
- Progress notes that clearly indicate the youth's response to therapeutic interventions;
- Updated amendments and updates to the treatment plan every 90 days include a specific update of the discharge plan for the youth;
- A consent form and other appropriate related medical information pertaining to the youth's treatment.

SUPPORT SYSTEMS: Outpatient treatment programs must have emergency services available by telephone 24 hours a day, seven days per week. Supervising Practitioners (Psychiatrist/Psychologist) must be available by telephone, pager or in person for consultation and supervision of the clinical treatment program. Clinically necessary medical, laboratory and toxicology services must be available on-site or through consultation or referral. If laboratory
services are required, providers must refer to Medicaid policy for regulations of laboratory services and payment for those services. Level I programs must provide a dual focus with dually licensed clinicians. Medical consultation must be available 24 hours per day by phone or in person and accessed within a timeframe appropriate to the severity and urgency of the consultation requested. Outpatient treatment programs must also have direct affiliation with or coordination through referral to more intensive levels of care and medication management as necessary.

DIAGNOSTIC ADMISSION CRITERIA:

- The youth is appropriately placed in a Level I program is assessed as meeting the diagnostic criteria for a substance-related disorder as defined in the current DSM-IV as well as the dimensional criteria for admission.
- The adolescent who is appropriately placed at Level I in a Level I program is assessed as meeting requirements for ALL of the following six dimensions.
- Continued stay is determined by reassessment of criteria and the response of the person to treatment.

- The following six dimensions and criteria are abbreviated. Providers are responsible to refer to the ASAM PPC-2R ADOLESCENT PLACEMENT MANUAL for the complete criteria.
  
  - **DIMENSION 1: ACUTE INTOXICATION AND/OR WITHDRAWAL:** The adolescent is not experiencing withdrawal acute or subacute withdrawal from alcohol or drugs and is not at risk for acute withdrawal or if the adolescent is experiencing mild withdrawal, the symptoms consist of no more than lingering but improving sleep disturbance.
  
  - **DIMENSION 2: BIOMEDICAL CONDITIONS AND COMPLICATIONS:** In Level I, the adolescent is not posing any biomedical conditions or complications and therefore is sufficiently stable to permit participation in outpatient treatment.
  
  - **DIMENSION 3: EMOTIONAL, BEHAVIORAL OR COGNITIVE CONDITIONS AND COMPLICATIONS:** Dangerousness - youth has adequate impulse control to deal with thoughts of harm to self or others. Youth's treatment poses no problems in recovery efforts, social functioning, or ability for self-care. The youth's mental status does not preclude his ability to understand materials presented nor to participate in treatment.
  
  - **DIMENSION 4: READINESS TO CHANGE:** The adolescent status is characterized by one of the following:
    - Willingness to cooperate with the treatment plan and attend therapy sessions. A structured milieu not required; and
    - Adolescent acknowledges an alcohol or drug problem and wants help to change; however, is ambivalent about recovery efforts. Requires monitoring and motivation strategies; or
    - The adolescent has co-occurring mental and substance-related disorders and is able to acknowledge the psychiatric diagnosis but resistant to the substance use diagnosis or vice versa; or
    - The adolescent admits he or she has an alcohol or drug problem but is more invested in avoiding a negative consequence than in recovery efforts. The adolescent requires monitoring and motivation strategies to help with engagement in treatment and to facilitate progress through stages of change.
  
  - **DIMENSION 5: RELAPSE, CONTINUED USE OR CONTINUED PROBLEM POTENTIAL:** The adolescent is able to significantly reduce his or her substance use or to achieve and maintain abstinence and recovery goals with only minimum support. The adolescent needs regular therapeutic contact to help him or her deal with the issues that include but are not limited to: preoccupation with alcohol or other drug usage, craving, peer pressure or impulse control and lifestyle and attitudinal changes.
  
  - **DIMENSION 6: RECOVERY ENVIRONMENT:**
    - The adolescent's psychosocial environment is sufficiently supportive that outpatient treatment is feasible; or
• The adolescent does not have the ideal primary or social support system to assist with immediate sobriety but has demonstrated motivation and willingness to obtain such a support system; or
• The adolescent's family, guardian and/or caretaker are supportive but require professional interventions to improve the adolescent's chances of treatment success and recovery. Interventions may involve assistance in monitoring and supervision techniques, limit setting and communication skills or a reduction in rescuing behaviors.

**Discharge/Transfer Criteria**

It is appropriate to transfer or discharge the adolescent from the present level of care if he or she meets the following criteria:

1. The adolescent has achieved the goals articulated in his or her individualized treatment plan thus resolving the problem(s) that justified admission to the present level of care and the adolescent has a comprehensive relapse plan in place which is individualized for his/her specific needs.  
   OR
2. The adolescent has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan. Treatment at another level of care or type of service is therefore indicated.  
   OR
3. The adolescent has demonstrated a lack of capacity to resolve his or her problem(s). Treatment at another level of care or type of service is therefore indicated.  
   OR
4. The adolescent has experienced an intensification of his or her problem(s), or has developed a new problem(s), and can be treated effectively only at a more intensive level of care.

To document and communicate the adolescent’s readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the existing or new problem(s), the adolescent should be discharged or transferred, as appropriate.

(8-1-08)
INTENSIVE OUTPATIENT SUBSTANCE ABUSE TREATMENT (ASAM LEVEL II.1: INTENSIVE OUTPATIENT TREATMENT)

For Nebraska Medicaid Enrolled Providers, this subchapter applies to intensive outpatient programs (IOP) enrolled for this level of care by Medicaid and credentialed by the Nebraska Medicaid managed care program (NMMCP). Providers will adhere to the regulations and program descriptions of the Nebraska Medical Assistance Program (NMAP) Chapter 32, (471 NAC 32-001 Intensive Outpatient Services) and the Medicaid Managed Care Program description for intensive outpatient programs as described in the Managed Care Handbook Supplement, Appendix B.

The following is based on the Adolescent Criteria of the Patient Placement Criteria for Treatment of Substance-Related Disorders of the American Society of Addiction Medicine Second Edition Revised (ASAM PPC-2R or current version) pages 220-233. Providers are responsible to refer to the ASAM PPC-2R ADOLESCENT PLACEMENT MANUAL for the complete criteria.

SERVICES: Intensive outpatient services may be delivered in any appropriate community setting that meets State licensure requirements in Nebraska as a Substance Abuse Treatment Center. Such treatment may be offered during the day, before or after work or school, in the evening or on a weekend. The services follow a defined set of policies and procedures or clinical protocols. IOP services also provide a coordinated set of individualized treatment services to youth who are able to function in a school, work and family environment but are in need of treatment services beyond traditional outpatient programs. Treatment may appropriately be used to transition youth from higher levels of care or maybe provided for youth at risk of being admitted to higher levels of care. Level II Programs provide essential treatment services while allowing adolescents to apply their newly acquired skills in the “real world” environment.

DETOXIFICATION SERVICES: Providers are referred to Level IV Acute Inpatient Hospital Detoxification Services (med-surg) for medically-managed intensive inpatient detoxification services.

HOURS: Intensive Outpatient Programs provide a minimum of nine hours per week of structured treatment services. Some youth may require up to 15 hours of intensive outpatient treatment services. As youth are progressing toward their recovery goals, programs may taper down to 6 hours per week.

STAFFING: IOP’s are staffed by an interdisciplinary team of appropriately credentialed mental health and addiction treatment professionals, including addiction-experienced psychiatrists and psychologists, who assess and treat substance-related disorders and mental health disorders. Program staff are able to obtain and interpret information regarding the youth’s biopsychosocial needs. Some, if not all, program staff must have had sufficient cross training to understand the signs and symptoms of mental disorders and to understand and explain the uses of psychotropic medications and their interactions with substance-related disorders.

THERAPIES: Therapies offered at a Level II.1 programs include –

- A minimum of 9 hours per week of skilled, structured treatment services. Available services must include individual, group and family therapy/counseling, medication management, and psychoeducational groups. Services are provided in amounts, frequencies, and intensities appropriate to the objectives of each adolescent's individualized treatment plan.
- Family therapy must involve significant family members and the youth. Families/guardians/caregivers and significant other interested parties are involved in the
assessment, treatment and continued care of the youth as appropriate to the youth's needs.

- A planned format of therapies delivered on an individual and group basis and adapted to the adolescent's developmental age and comprehension level.
- Motivational enhancement and engagement strategies are used in preference to the confrontational approaches.

ASSESSMENT/TREATMENT PLAN REVIEW: In Level II.1 programs, the assessment and treatment plan include –

- A comprehensive substance abuse history as obtained as part of the initial assessment (pretreatment assessment) (biopsychosocial assessment and the initial diagnostic interview) provided to the youth prior to admission.
- An updated initial diagnostic interview provided by the IOP supervising practitioner who reviews the outpatient assessment and confirms the diagnosis and the appropriateness of the level of care.
- A physical examination as determined by the adolescent’s medical condition and needs and the program standards.
- An individualized treatment plan including problem formulization and articulation of short-term, measurable treatment goals and treatment services designed to achieve those goals. The plan is developed and reviewed in consultation with the youth and family/guardian/caregiver and reflects the youth's personal goals. The initial plan must be completed within two weeks of admission and the treatment plan must be reviewed every 30 days thereafter.

LENGTH OF STAY: The duration of treatment varies with the severity of the adolescent’s illness and his or her response to treatment. The frequency of intensive outpatient services may decrease as the youth moved toward completing their treatment goals and is increasingly ready to move toward discharge from the program.

DOCUMENTATION: Documentation requirements for Level II.1 programs must include assessments, treatment plans, and individualized progress notes in the adolescent’s clinical record. The progress notes clearly reflect implementation of the treatment plan and the adolescent's response to the therapeutic interventions for all disorders treated, as well as subsequent amendments to the plan. The discharge plan is identified and refined in each plan update and documented as the youth moves closer to discharge from this level of care.

SUPPORT SERVICES: Level II.1 treatment programs must have psychiatric consultation and the capacity to arrange for medical consultation, psycho-pharmacological consultation, medication management, laboratory services and 24-hour crisis services. Beyond the essential services, many Level II.1 programs provide psycho-pharmacological assessment and treatment. All programs must have the capacity to effectively treat youth who have complex co-occurring mental and substance-related disorders. In addition, the Programs have active affiliation with other levels of care and can help the youth assess support services such as transportation and vocational training.

DIAGNOSTIC ADMISSION CRITERIA:

- The adolescent who is appropriately placed in a Level II.1 program meets the diagnostic criteria for a Substance-Related Disorder or a co-occurring psychiatric disorder as defined in the current DSM IV (or current version).
- Direct admission to a Level II.1 program is advisable for the adolescent who meets the stability specifications in Dimension 1 (if any withdrawal problems exist) and in
Dimension 2 (if any biomedical conditions or problems exist) as well as the severity specification in one of the Dimensions 3, 4, 5 or 6.

- Transfer to Level II.1 program is appropriate for an adolescent who has met the objectives of treatment in a more intensive level of care and who requires the intensity of service provided in Level II.1 in at least one dimension.
- The adolescent also may be transferred to a Level II.1 from a Level I program when the services provided at a Level I have proved insufficient to address the adolescent’s needs or when Level I services have consisted of motivational interventions to prepare the adolescent for participation in a more intensive level of care for which he or she now meets admission criteria.
- Continued stay is determined by reassessment of admission criteria and response to treatment
- The following six dimensions and criteria are abbreviated. Providers are responsible to refer to the ASAM PPC-2R ADOLESCENT PLACEMENT MANUAL for complete criteria.

- **DIMENSION 1 ACUTE INTOXICATION AND/OR WITHDRAWAL:** The adolescent is not experiencing or at risk of acute withdrawal. The adolescent is likely to attend, engage and participate in treatment. The adolescent is able to tolerate mild sub acute withdrawal symptoms, has made a commitment to sustain treatment and to follow treatment recommendations and has external supports (family and/or court) that promote engagement in treatment.

- **DIMENSION 2 BIO-MEDICAL CONDITIONS AND COMPLICATIONS:** The adolescent’s bio-medical conditions, if any, are stable or are concurrently being addressed and will not interfere with treatment at this level of care or the adolescent's bio-medical conditions and problems are severe enough to distract from recovery and treatment at a less intensive level of care but will not interfere with recovery at Level II.1. The bio-medical conditions and problems are being addressed concurrently by the medical treatment provider.

- **DIMENSION 3 EMOTIONAL, BEHAVIORAL OR COGNITIVE CONDITIONS AND COMPLICATIONS:** The adolescent status is characterized by one of the following:
  - The adolescent is at mild risk of behaviors endangering self, others or property and requires frequent monitoring to assure there is a reasonable likelihood of safety between intensive outpatient sessions. The adolescent's condition is not so severe to require daily supervision.
  - The adolescent’s recovery efforts are negatively affected by emotional, behavioral or cognitive problems which cause mild interferences and require increased intensity to support treatment participation and compliance.
  - The adolescent's symptoms are causing mild to moderate difficulty in social functioning but not to such a degree that he or she is unable to manage the activities of daily living or to fulfill responsibilities at home, school, work or community.
  - The adolescent is experiencing mild to moderate impairment in the ability to manage the activities of daily living and thus requires frequent monitoring and treatment interventions.
  - The adolescent's history and present conditions suggest that an emotional, behavioral or cognitive condition would become unstable without frequent monitoring and maintenance.

- **DIMENSION 4 READINESS TO CHANGE:**
  - The adolescent requires structured therapy and a programmatic milieu to promote progress through the stages of change.
• The adolescent is verbally compliant but does not demonstrate consistent behaviors.
• The adolescent is only passively involved in treatment.
• The adolescent demonstrates variable compliance with attendance in outpatient sessions or mutual self-help meetings or support groups.
• The adolescent’s perspective inhibits his or her ability to make progress through the stages of change. The adolescent thus requires structured therapy and a programmatic milieu. Such interventions are not likely to succeed in Level I service.

**DIMENSION 5 RELAPSE, CONTINUED USE OR CONTINUED PROBLEM POTENTIAL:** The adolescent’s status is characterized by the following:
• Is at significant risk of relapse or continued use as well as deterioration in the level of functioning without frequent outpatient monitoring and therapeutic services.
• The adolescent demonstrates impaired recognition and understanding of relapse issues. The adolescent is able to avoid continued use or relapse only with moderate treatment support available.

**DIMENSION 6 RECOVERY ENVIRONMENT:** The adolescent status is characterized by one of the following:
• Continued exposure to the adolescent’s current school, work or living environment will impede recovery. He or she has insufficient resources and skills necessary to maintain adequate level of functioning without the services of a Level II.1 program, but is capable of maintaining an adequate level of functioning between or sessions.
• The adolescent lacks social contact or has inappropriate social contacts that jeopardize recovery or has few friends or peers who do not use alcohol or drugs.
• The adolescent’s family or caretakers are supportive of recovery but family conflicts and related family dysfunctions impede the adolescent’s ability to learn the skills necessary to achieve and maintain abstinence.

**Discharge/Transfer Criteria**

It is appropriate to transfer or discharge the adolescent from the present level of care if he or she meets the following criteria:

1. The adolescent has achieved the goals articulated in his or her individualized treatment plan thus resolving the problem(s) that justified admission to the present level of care and has a comprehensive relapse plan in place which addresses his/her specific needs.

   **OR**

2. The adolescent has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan. Treatment at another level of care or type of service is therefore indicated.

   **OR**

3. The adolescent has demonstrated a lack of capacity to resolve his or her problem(s). Treatment at another level of care or type of service is therefore indicated.

   **OR**

4. The adolescent has experienced an intensification of his or her problem(s), or has developed a new problem(s), and can be treated effectively only at a more intensive level of care.

To document and communicate the adolescent’s readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the
criteria apply to the existing or new problem(s), the adolescent should be discharged or transferred, as appropriate.

(8-1-08)
DAY TREATMENT SUBSTANCE ABUSE TREATMENT (ASAM LEVEL II.1: INTENSIVE OUTPATIENT TREATMENT)

For Nebraska Medicaid Enrolled Providers, this subchapter applies to Day Treatment programs enrolled for this level of care by Medicaid and credentialed by the Nebraska Medicaid managed care program (NMMCP). Providers will adhere to the regulations and program descriptions of the Nebraska Medical Assistance Program (NMAP) Chapter 32 (471 NAC 32-004 Day Treatment Services) and the Medicaid Managed Care Program description for day treatment programs as described in the Managed Care Handbook Supplement, Appendix B.

The following is based on the Adolescent Criteria of the Patient Placement Criteria for the Treatment of Substance-Related Disorders of the American Society of Addiction Medicine, Second Edition Revised (ASAM PPC-2R or current version) pages 220-233. Providers are responsible to refer to the ASAM PPC-2R ADOLESCENT PLACEMENT MANUAL for the complete criteria.

SERVICES: Day treatment services may be delivered in any appropriate community or hospital setting that meets State licensure requirements in Nebraska as a Substance Abuse Treatment Center. Such treatment may be offered during the day, before or after work or school, in the evening or on a weekend. The services follow a defined set of policies and procedures or clinical protocols. The day treatment services also provide a coordinated set of individualized treatment services to youth who are able to function in a school, work and family environment but are in need of treatment services beyond traditional outpatient programs or intensive outpatient programs. Treatment may appropriately be used to transition youth from higher levels of care or maybe provided for youth at risk of being admitted to higher levels of care. Level II programs provide essential mental health and substance abuse psychoeducation and treatment services while allowing adolescents to apply their newly acquired skills in the “real world” environment. Day treatment providers have contracted for pharmacy, psychology, and dietary services as necessary.

DETOXIFICATION SERVICES: Providers are referred to Level IV Acute Inpatient Hospital Detoxification Services (med-surg) for medically-managed intensive inpatient detoxification services.

HOURS: Day treatment programs offer a minimum of nine hours per week of structured treatment services, however, day treatment programs must be available a minimum of three hours per day, five days per week. Some youth may require up to 15 or more hours of day treatment services per week. As youth are progressing toward their recovery goals, programs may taper down to as few as 6 hours per week.

STAFFING: Day treatment programs are staffed by an interdisciplinary team of appropriately credentialed addiction and mental health treatment professionals, including addiction-experienced psychiatrists and psychologists, who assess and treat substance-related disorders. Program clinicians are able to obtain and interpret information regarding the youth’s biopsychosocial needs. Some, if not all, program staff may have had sufficient cross-training to understand the signs and symptoms of mental disorders. Appropriately credentialed staff understands and can administer and explain the uses of psychotropic medications and their interactions with substance-related disorders.

THERAPIES: Therapies offered at a Level II.1 programs include –

- A minimum of 9 hours per week of skilled, structured treatment services. Available services must include individual, group and family counseling, medication management, and psychoeducational groups. Services are provided in amounts, frequencies, and intensities appropriate to the objectives of the individualized treatment plan.
• Programs must be offered five times weekly and services are provided in the amounts, frequencies and intensities appropriate to the objective of each adolescent's individualized treatment plan.
• Family therapy must involve significant family members and the youth. Families/caregivers/guardians or significant other interested parties are involved in the assessment, treatment and continued care of the youth as appropriate to the youth's treatment needs.
• A planned format of therapies delivered on an individual and group basis and adapted to the adolescent’s developmental age and comprehension level.
• Motivational enhancement and engagement strategies are used in preference to the confrontational approaches.

**ASSESSMENT/TREATMENT PLAN:** In Level II.1 programs, the assessment and treatment plan review include –

• A comprehensive substance abuse history as obtained as part of the initial assessment (biopsychosocial assessment provided to the youth prior to admission.
• An initial diagnostic interview by the supervising practitioner, (psychologist or psychiatrist).
• An update of the initial diagnostic interview by the day treatment supervising practitioner, who reviews prior clinical information and verifies diagnosis and appropriateness of the level of care.
• A physical examination as determined by the adolescent’s medical condition and needs and the program standards.
• An individualized treatment plan including problem formulization and articulation of short-term measurable treatment goals and treatment services designed to achieve those goals. The plan is developed and reviewed in consultation with the youth and family/guardian and reflects the youth’s personal goals. The initial plan must be completed within two weeks of admission and the treatment plan must be reviewed every 30 days thereafter.

**LENGTH OF STAY:** The duration of treatment varies with the severity of the adolescent’s illness and his or her response to treatment.

**DOCUMENTATION:** Documentation requirements for Level II.1 programs include a clinical record for each youth that contains assessments, treatment plans and updates, and individualized progress notes. The notes clearly reflect implementation of the treatment plan and the adolescent’s response to the therapeutic interventions for all disorders treated, as well as subsequent amendments to the plan. The discharge plan is identified and refined with each plan update and documented in the clinical record as youth progress through treatment toward discharge from this level of care.

**SUPPORT SERVICES:** Level II.1 treatment programs have psychiatric consultation and the capacity to arrange for medical consultation, psycho-pharmacological consultation, medication management, laboratory services and 24-hour crisis services. Beyond the essential services, many Level II.1 programs provide psycho-pharmacological assessment and treatment. All programs must have the capacity to effectively treat youth who have complex co-occurring mental and substance-related disorders. In addition, the Programs have active affiliation with other levels of care and can help the youth assess support services such as transportation and vocational training.
DIAGNOSTIC ADMISSION CRITERIA:

- The adolescent is appropriately placed in a Level II.1 program meets the diagnostic criteria for a Substance-Related Disorder or a co-occurring psychiatric disorder as defined in the current DSM IV (or current version) as well as the dimensional criteria for admission.
- Direct admission to a Level II.1 program is advisable for the adolescent who meets the stability specifications in Dimension 1 (if any withdrawal problems exist) and in Dimension 2 (if any biomedical conditions or problems exist) as well as the severity specification in one of the Dimensions 3, 4, 5 or 6.
- Transfer to Level II.1 program is appropriate for an adolescent who has met the objectives of treatment in a more intensive level of care and who requires the intensity of service provided in Level II.1 in at least one dimension.
- The adolescent also may be transferred to a Level II.1 from a Level I program when the services provided at a Level I have proved insufficient to address the adolescent's needs or when Level I services have consisted of motivational interventions to prepare the adolescent for participation in a more intensive level of care for which he or she now meets admission criteria.
- Continued stay is determined by reassessment of admission criteria and response to treatment.
- The following six dimensions and criteria are abbreviated. Providers are responsible to refer to the ASAM PPC-2R ADOLESCENT PLACEMENT MANUAL for complete criteria.

  - **DIMENSION 1 ACUTE INTOXICATION AND/OR WITHDRAWAL:** The adolescent is not experiencing or at risk of acute withdrawal. The adolescent is likely to attend, engage and participate in treatment. The adolescent is able to tolerate mild sub acute withdrawal symptoms, has made a commitment to sustain treatment and to follow treatment recommendations and has external supports (family and/or court) that promote engagement in treatment.

  - **DIMENSION 2 BIO-MEDICAL CONDITIONS AND COMPLICATIONS:** The adolescent's bio-medical conditions, if any, are stable or are concurrently being addressed and will not interfere with treatment at this level of care or the adolescent's bio-medical conditions and problems are severe enough to distract from recovery and treatment at a less intensive level of care but will not interfere with recovery at Level II.1. The bio-medical conditions and problems are being addressed concurrently by the medical treatment provider.

  - **DIMENSION 3 EMOTIONAL, BEHAVIORAL OR COGNITIVE CONDITIONS AND COMPLICATIONS:** The adolescent status is characterized by one of the following:
    - The adolescent is at mild risk of behaviors endangering self, others or property and requires frequent monitoring to assure there is a reasonable likelihood of safety between intensive outpatient sessions. The adolescent's condition is not so severe to require daily supervision.
    - The adolescent's recovery efforts are negatively affected by emotional, behavioral or cognitive problems which cause mild interferences and require increased intensity to support treatment participation and compliance.
    - The adolescent's symptoms are causing mild to moderate difficulty in social functioning but not to such a degree that he or she is unable to manage the activities of daily living or to fulfill responsibilities at home, school, work or community.
• The adolescent is experiencing mild to moderate impairment in the ability to manage the activities of daily living and thus requires frequent monitoring and treatment interventions.
• The adolescent’s history and present conditions suggest that an emotional, behavioral or cognitive condition would become unstable without frequent monitoring and maintenance.

• **DIMENSION 4 READINESS TO CHANGE:**
  • The adolescent requires structured therapy and a programmatic milieu to promote progress through the stages of change.
  • The adolescent is verbally compliant but does not demonstrate consistent behaviors.
  • The adolescent is only passively involved in treatment.
  • The adolescent demonstrates variable compliance with attendance in outpatient sessions or mutual self-help meetings or support groups.
  • The adolescent’s perspective inhibits his or her ability to make progress through the stages of change. The adolescent thus requires structured therapy and a programmatic milieu. Such interventions are not likely to succeed in Level I service.

• **DIMENSION 5 RELAPSE, CONTINUED USE OR CONTINUED PROBLEM POTENTIAL:** The adolescent’s status is characterized by the following:
  • Is at significant risk of relapse or continued use as well as deterioration in the level of functioning without frequent outpatient monitoring and therapeutic services.
  • The adolescent demonstrates impaired recognition and understanding of relapse issues. The adolescent is able to avoid continued use or relapse only with moderate treatment support available.

• **DIMENSION 6 RECOVERY ENVIRONMENT:** The adolescent status is characterized by one of the following:
  • Continued exposure to the adolescent’s current school, work or living environment will impede recovery. He or she has insufficient resources and/or skills necessary to maintain adequate level of functioning without the services of a Level II.1 program, but is capable of maintaining an adequate level of functioning between or sessions.
  • The adolescent lacks social contact or has inappropriate social contacts that jeopardize recovery or has few friends or peers who do not use alcohol or drugs.
  • The adolescent’s family or caretakers are supportive of recovery but family conflicts and related family dysfunctions impede the adolescent’s ability to learn the skills necessary to achieve and maintain abstinence.

**Discharge/Transfer Criteria**

It is appropriate to transfer or discharge the adolescent from the present level of care if he or she meets the following criteria:

1. The adolescent has achieved the goals articulated in his or her individualized treatment plan thus resolving the problem(s) that justified admission to the present level of care and has a comprehensive relapse plan in place which addresses his/her specific needs.
   OR
2. The adolescent has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan. Treatment at another level of care or type of service is therefore indicated.  
   OR
3. The adolescent has demonstrated a lack of capacity to resolve his or her problem(s). Treatment at another level of care or type of service is therefore indicated.  
   OR
4. The adolescent has experienced an intensification of his or her problem(s), or has developed a new problem(s), and can be treated effectively only at a more intensive level of care.

To document and communicate the adolescent’s readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the existing or new problem(s), the adolescent should be discharged or transferred, as appropriate.

(8-1-08)
PARTIAL HOSPITALIZATION SUBSTANCE ABUSE TREATMENT (ASAM LEVEL II.5 PARTIAL HOSPITALIZATION)

For Nebraska Medicaid Enrolled Providers, this subchapter applies to providers of Partial Hospitalization who are Medicaid enrolled and credentialed by the Nebraska Medicaid managed care program (NMMCP) for this level of care. Providers will need to adhere to the regulations and program descriptions of the Nebraska Medical Assistance Program (NMAP) Chapter 32 (471 NAC 32-004 Day Treatment Services) and the Nebraska Medicaid managed care program descriptions for partial hospitalization programs as described in the Managed Care Handbook Supplement, Appendix B.

The following is based on the Adolescent Criteria of the Patient Placement Criteria for the Treatment of Substance Related Disorders of the American Society of Addiction Medicine, Second Edition Revised (ASAM PPC-2R or current version) pages 220-233. Providers are responsible to refer to the ASAM PPC-2R Adolescent Placement Manual for complete criteria.

SERVICES: Partial hospitalization services may be delivered in a licensed substance abuse treatment center usually located in a psychiatric hospital or wing of an acute care hospital. Programs may be licensed as hospitals. A community based facility with a mental health center license in addition to a substance abuse treatment center license. Typically, partial hospitalization serves youth with acute medical needs which require frequent physician/psychiatric involvement. Substance abuse treatment may be offered during the day before or after work or school, in the evening or on the weekend. Partial hospitalization provides a coordinated set of individualized treatment services to persons who are able to function in a school, work or family environment but are in need of treatment services beyond traditional outpatient or intensive outpatient programs or day treatment programs. Treatment may appropriately be used to transition persons from higher levels of care or may be provided for persons at risk of becoming admitted to higher levels of care. Essential education and treatment services are provided while allowing the adolescent to apply their newly acquired skills in the “real world” environment.

DETOXIFICATION SERVICES: Providers are referred to Level IV Acute Inpatient Hospital Detoxification Services (med-surg) for medically managed intensive inpatient detoxification services.

HOURS: Partial hospitalization programs are required to offer 30 or more hours per week of clinically intensive programming as specified by the youth’s treatment plan. Most substance abuse programs are available six hours per day and at a minimum of five days per week. Youth's treatment plan identifies 20-30 hours per week of treatment.

STAFFING: Staff includes an interdisciplinary team of appropriately credentialed addiction and mental health treatment professionals including a psychiatrist and other physicians who are trained to assess and treat mental health as well as substance abuse disorders. One or more professional addiction licensed clinicians are on-site and involved in direct care during programming hours. Program staff is able to obtain and interpret information regarding the patient’s biopsychosocial needs. Program staff must have sufficient cross-training to understand the signs and symptoms of mental disorders and substance abuse disorders and to understand and explain the uses of psychotropic medication and their interactions with substance related disorders.

THERAPIES:
- Direct access to a psychiatrist and referral relationship for mental health and laboratory services.
• Therapies offered by Level II.5 programs generally feature 30 hours or more per week of treatment services. Services must include individual, family and group counseling by a licensed clinician, medication management by a psychiatrist, and medication education groups by a physician or licensed registered nurse. Services are provided in amounts, frequencies and intensities appropriate to the objectives of each youth's individualized treatment plan and address the youth's developmental and comprehension level.

• Family therapy involving appropriate family members and the youth, and may also involve guardians/caregivers or significant others in the assessment, treatment and continued care of the adolescent and play a vital role in the youth's recovery. Involvement of appropriate individuals must meet the youth's treatment needs.

• A planned format of therapies delivered on an individual and group basis may include cognitive therapy, behavioral modification, psychoeducational groups and counseling services and may also involve recreational and occupational therapy.

• Coordination with the school system in order to access and meet the youth's educational needs. This coordination is provided by the treatment staff and is part of the youth's treatment plan.

ASSESSMENT/TREATMENT REVIEW:
In Level II.5 programs, elements of the assessment and treatment plan review include:

• A comprehensive substance abuse and mental health history obtained as part of the biopsychosocial assessment and reviewed by the treatment team. Information obtained from a parent/guardian or other important resources is essential to the assessment.

• The initial diagnostic interview by a psychiatrist.

• A physical examination as determined by the youth’s medical condition, the youth’s needs and by program standards.

• An individualized treatment plan including identifying the problem, and formulization and articulation of short term, measurable treatment goals and activities designed to achieve those goals. A plan that is developed and reviewed in consultation with the adolescent and reflects the adolescent’s personal goals. The individual plan is completed within 24 hours of admission and is reviewed in consultation with the adolescent and his/her family every seven days thereafter.

• An aggressive discharge plan and transition to the next clinically necessary level of care as a part of the individualized treatment plan.

LENGTH OF STAY: The duration of treatment varies with the severity of the adolescent's illness and his/her response to treatment. Treatment is highly individualized and the length of stay must be dependent upon the treatment needs of the youth. The length of stay must be individualized to the treatment needs of the youth.

DOCUMENTATION: Documentation requirements regarding Level II.5 programs include:

• Substance abuse and mental health assessment included in a biopsychosocial assessment (Part I of the pretreatment assessment).

• The initial diagnostic interview by the psychiatrist or psychologist.

• The nursing assessment

• Treatment plan and treatment plan updates.

• All other medical consultations.

• Daily progress notes of the treatment team.

• Therapy/counseling notes for each treatment session.

• Appropriate consent and release of information form signed by the youth and/or guardian as appropriate.

SUPPORT SYSTEMS: Level II.5 programs must provide psychiatric, medical and laboratory services and have direct access to medical services. These programs are, therefore, better able than Level II.1 programs to meet needs identified in dimensions 1, 2 and 3 which warrant daily monitoring or management but which can be appropriately addressed in a structured
Patient who meet Level III criteria in dimensions 4, 5, and 6 and who otherwise would be placed in a Level III program may be considered for treatment in a Level II.5 program if the adolescent resides in a facility or home that provides 24-hour support and structure and that limits access to alcohol and other drugs. Mandatory support systems for Level II.5 include medical, laboratory and toxicology services available onsite or through consultation or referral. Psychiatric and medical consultation is available immediately by phone and within 24 hours for direct services in person. Emergency services are available 24 hours a day, seven days a week when the program is not in session and direct affiliation with more or less intensive levels of care. Beyond the essential services, many Level II.5 programs provide psychopharmacological assessment and treatment and the capacity to effectively treat adolescents who have complex co-occurring mental and substance-related disorders.

**DIAGNOSTIC ADMISSION CRITERIA:**

- The adolescent who is appropriately placed at a Level II.5 program for substance abuse treatment is assessed as meeting the diagnostic criteria for a Substance Related disorder or a co-occurring psychiatric disorder as defined in the Diagnostic and Statistical Manual for Mental Disorders (DSM IV or current version) as well as the dimensional criteria for admission.
- If the adolescent presenting alcohol or drug history is inadequate to substantiate such a diagnosis, the probability of such diagnosis may be determined from the information of collateral parties, i.e., parents, caregivers, guardians.
- Direct admission to a Level II.5 program is advisable for the adolescent who meets stability specifications in dimensions 1 and 2 as well as the severity specifications of one of the Dimensions 1, 3, 4, 5, 6.
- Continued stay is determined by reassessment of admission criteria and response to treatment.
- Transfer to a Level II.5 program is advisable for the adolescent who has meet the treatment objectives at a more intensive level of care and who requires the intensity of services provided in a Level II.5 in at least one dimension.
- An adolescent also may be transferred to a Level II.5 from a Level I or a Level II.1 program when services provided at those levels have proved insufficient to address the adolescent’s needs or when Level I or Level II.1 services have consisted of motivational interventions to prepare the adolescent for participation in more intensive levels of care for which he or she now meets admission criteria.
- The following six dimensions are criteria that are abbreviated. Providers are responsible to refer to the ASAM PPC-2R (or current version) Adolescent Placement Manual for more information.

**DIMENSION 1 ACUTE INTOXICATION AND/OR WITHDRAWAL:** The adolescent appropriately placed in a Level II.5 is:

- Experiencing acute or subacute withdrawal marked by mild symptoms that are diminishing.
- The adolescent is likely to attend, engage and participate in treatment as evidenced by the following:
  - The youth is able to tolerate mild withdrawal symptoms;
  - The youth has made a commitment to sustain treatment and to follow treatment recommendations; and
  - The youth has external supports as from family and/or court that promote treatment engagement.

**DIMENSION 2 BIO-MEDICAL CONDITIONS AND COMPLICATIONS:** In Dimension 2:

- The adolescent’s biomedical conditions and problems are stable or are being concurrently addressed and will not interfere with treatment at this level of care;
• The adolescent’s biomedical conditions and problems are severe enough to distract from recovery and treatment at a lower level of care but will not interfere with recovery at Level II.5. The biomedical conditions and problems are being addressed concurrently by the medical treatment provider.

• DIMENSION 3 EMOTIONAL, BEHAVIORAL OR COGNITIVE CONDITIONS AND COMPLICATIONS: The adolescent’s status at Dimension 3 is characterized by one of the following:
  • Dangerousness/lethality - The adolescent is at mild risk of behaviors endangering self, others or property and requires frequent monitoring to assure reasonable likelihood of safety during non-treatment hours. However, his or her condition is not severe to require 24-hour supervision.
  • Interface with addiction recovery efforts - The adolescent’s recovery efforts are negatively affected by emotional, behavioral or cognitive problem which causes moderate interference with and requires increased intensity to support treatment participation and/or compliance.
  • Social functioning - The adolescent’s symptoms are causing mild to moderate difficulty in social functioning but not to such a degree that the adolescent is unable to manage the activities of daily living or to fulfill responsibilities at home, school, work or community. Alternatively, the adolescent may be transitioning back to the community in a step-down from an institutional setting.
  • Ability for self-care - The adolescent is experiencing moderate impairment in the ability to manage activities of daily living and thus requires near daily monitoring and treatment interventions. Problems may involve disorganization and inability to manage the demands of daily self-scheduling, a progressive pattern of promiscuous or unprotected sexual contacts, or poor vocational or pre-vocational skills that require habilitation and training provided by the program.
  • Course of illness - The adolescent’s history and present situation suggest that an emotional, behavioral, or cognitive condition would become unstable without daily or near daily monitoring and maintenance.

• DIMENSION 4 READINESS TO CHANGE: The adolescent status is characterized by:
  • The adolescent requires structured therapy and programmatic milieu to promote progress through the stages of change as evidenced by the following:
    • The adolescent demonstrates verbal and behavioral opposition to treatment,
    • The adolescent is only minimally involved in treatment,
    • The adolescent demonstrates poor compliance with attendance at outpatient sessions, or
    • The adolescent’s alcohol and drug use is escalating, contributing to school failure, truancy or behaviors leading to suspension from school.
  • The adolescent’s perspective and lack of impulse control inhibits the adolescent’s ability to make progress through stages of change. The adolescent thus requires structured therapy and a programmatic milieu. Such interventions are not feasible or likely to succeed in a Level II.1 service. However, the adolescent’s resistiveness is not so high as to render treatment ineffective.

• DIMENSION 5 RELAPSE, CONTINUED USE OR CONTINUED PROBLEM POTENTIAL: The adolescent’s status in Dimension 5 is characterized by the following:
  • The adolescent is at high risk of relapse or continued use without almost daily outpatient monitoring and structured therapeutic services. Treatment at a less intensive level of care has been attempted or given serious consideration and has been judged insufficient to stabilize the adolescent’s condition.
The adolescent demonstrates impaired recognition and understanding of relapse issues. The adolescent has such poor skills in coping with, and interrupting substance use problems and avoiding or limiting relapse that the near daily structure afforded by Level II.5 is needed to prevent or arrest significant deterioration in functioning.

**DIMENSION 6 RECOVERY ENVIRONMENT:** The adolescent’s status in Dimension 6 is characterized by:

- Continued exposure to the adolescent’s current school, work or living environment will render recovery unlikely. The adolescent lacks the resources or skills necessary to maintain an adequate level of function without the services of a Level II.5 program. The youth is capable of maintaining an adequate level of functioning between sessions.
- The adolescent lacks social contacts or has inappropriate social contacts that jeopardize recovery or has few friends or peers who do not use alcohol or drugs. The adolescent has insufficient resources or skills necessary to maintain an adequate level of functioning without the services of Level II.5 program but is capable of maintaining an adequate level of functioning between sessions.
- Family members and/or significant others living with the adolescent are not supportive of his or her recovery goals and/or are passively opposed to treatment. The adolescent requires structured treatment services and relief from the home environment in order to remain focused on recovery but he or she may live at home because there is active opposition to or sabotaging of the recovery effort.

**Discharge/Transfer Criteria**

It is appropriate to transfer or discharge the adolescent from the present level of care if he or she meets the following criteria:

1. The adolescent has achieved the goals articulated in his or her individualized treatment plan thus resolving the problem(s) that justified admission to the present level of care and has a comprehensive relapse plan in place which addresses his/her specific needs.
   OR
2. The adolescent has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan. Treatment at another level of care or type of service is therefore indicated.
   OR
3. The adolescent has demonstrated a lack of capacity to resolve his or her problem(s). Treatment at another level of care or type of service is therefore indicated.
   OR
4. The adolescent has experienced an intensification of his or her problem(s), or has developed a new problem(s), and can be treated effectively only at a more intensive level of care.

To document and communicate the adolescent’s readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the existing or new problem(s), the adolescent should be discharged or transferred, as appropriate.

(8-1-08)
TREATMENT FOSTER CARE SUBSTANCE ABUSE TREATMENT (ASAM LEVEL II.5 PARTIAL HOSPITALIZATION)

For Nebraska Medicaid Enrolled Providers of treatment services, this subchapter applies to treatment foster care programs that are enrolled by Medicaid and credentialed by the Nebraska Medicaid managed care program (NMMCP). Providers will need to adhere to the regulations and program descriptions of the Nebraska Medical Assistance Program (NMAP) Chapter 32 (471 NAC 32-005 Treatment Foster Care Services) and the Nebraska Medicaid managed care program descriptions for treatment foster care as described in the Managed Care Handbook Supplement, Appendix B.

The following is based on the Adolescent criteria of the Patient Placement Criteria for the Treatment of Substance Related Disorders of the American Society of Addiction Medicine, Second Edition Revised (ASAM PPC-2R or current version) pages 220-233. Providers are responsible to refer to the ASAM PPC-2R Adolescent Placement Manual for complete criteria.

SERVICES: Treatment foster care services with a substance abuse focus may be delivered in an agency that is appropriately licensed as a treatment foster care agency in Nebraska. Treatment may be offered during the day, before or after work or school, in the evening or on the weekend. Treatment foster care agencies provide a coordinated set of individualized treatment services to persons who are able to function in a school, work or family environment but are in need of treatment services beyond traditional outpatient programs. Treatment may appropriately be used to transition persons from higher levels of care or may be provided to youth at risk of becoming admitted to higher levels of care. Treatment foster care programs with a substance abuse treatment focus provide essential education and treatment services by appropriately licensed clinicians while allowing the adolescent to apply their newly acquired skills in the “real world” environment and function in a healthy, nurturing, therapeutic family atmosphere. The treatment foster care parents and family are educated, knowledgeable and skilled in applying and delivering the agency's treatment philosophy in the home environment. Treatment foster care parents can deliver consistent treatment interventions in appropriate environments of the adolescent's life, such as school, social activities, etc.

DETOXIFICATION SERVICES: Providers are referred to Level IV Acute Inpatient Hospital Detoxification Services (med-surg) for medically managed intensive inpatient detoxification services.

HOURS: Treatment foster care programs are required to provide 20 or more hours per week of clinically intensive programming and supervise the provision of all treatment interventions provided in the home setting per week as specified by the youth’s treatment plan.

STAFFING: Staff includes an interdisciplinary team of appropriately credentialed addiction and mental health treatment professionals including a psychiatrist and other physicians who are trained to assess and treat substance as well as mental health related disorders. One or more professional addiction clinicians are on-site and involved in direct services during programming. The agency's treatment foster care program staff is able to obtain and interpret information regarding the youth's biopsychosocial needs. Treatment foster care parents must have basic chemical dependency knowledge through initial and ongoing training and through supervision by the treatment foster care specialist and director. Parents provide day-to-day interventions with youth in the home, school and social settings. Program staff must have sufficient cross-training to understand the signs and symptoms of mental disorders and to understand and explain the uses of psychotropic medication and their interactions with substance related disorders.

THERAPIES:
• Direct access to a psychiatrist and a close referral relationship to medical and laboratory services.
• Therapies offered by Level II.5 programs generally feature 20 hours or more per week of structured treatment services. In addition, youth are provided treatment interventions by the treatment foster care parents in the home environment. This may include teaching and coordinating treatment program assignments, supervising the attendance of AA and NA meetings, and encouraging development of healthy social activities. Services must include individual, family and group counseling by a licensed clinician, medication management by a physician, and medication education groups by a psychiatrist or nurse. Services are provided in amounts, frequencies and intensities appropriate to the objectives of each youth’s individualized treatment plan and address the youth’s developmental and comprehension level.
• Family therapy involving appropriate family members and committed caregivers and the youth and, in addition, may also involve treatment foster care parents, guardians or significant others in the assessment, treatment and continued care of the adolescent. Treatment foster care parents may act as a role model in the therapeutic home environment for the next caregiver/family that the youth may transition to.
• A planned format of therapies delivered on an individual and group basis may include cognitive therapy, behavioral modification, educational groups and may involve recreational and occupational therapy.
• Coordination with the school system in order to access and meet the youth’s educational needs. This coordination activity is provided by the treatment foster care parents and supervised by the treatment foster care agency.

ASSESSMENT/TREATMENT REVIEW:
In Level II.5 programs, elements of the assessment and treatment plan review include:
• A comprehensive substance abuse and mental health history obtained as part of the biopsychosocial assessment and reviewed by the treatment team.
• Initial Diagnostic Interview by the supervising psychiatrist or psychologist.
• A physical examination by a physician as determined by the youth’s medical condition, the youth’s needs and program standards.
• An individualized treatment plan including problem, formulation and articulation of short term, measurable treatment goals and activities designed to achieve those goals. The plan is developed and reviewed in consultation with the adolescent and reflects the adolescent’s personal goals. The initial plan must be completed within 24 hours of admission and the treatment plan must be reviewed in consultation with the adolescent and his/her family every seven days thereafter.
• Aggressive discharge plan and transition to the next clinically appropriate level of care.

LENGTH OF STAY: The duration of treatment varies with the severity of the adolescent’s illness and his/her response to treatment. Treatment must be highly individualized and length of stay is dependent upon the specific needs of each youth.

DOCUMENTATION: Documentation requirements for Level II.5 programs include:
• A substance abuse and mental health assessment (biopsychosocial assessment);
• An Initial Diagnostic Interview by the supervising psychiatrist or psychologist;
• The youth’s record must include the treatment plan and treatment plan updates;
• Therapist's progress notes reflecting youth’s response to treatment;
• Daily progress notes by a treatment foster staff member;
• Appropriate consents and releases of information signed by the youth and guardian as appropriate.

SUPPORT SYSTEMS: Level II.5 programs must have direct access to psychiatric, medical and laboratory services and are therefore better able than Level II.1 programs to meet needs identified in dimensions 1, 2 and 3 which warrant daily monitoring or management but which can
be appropriately addressed in a structured outpatient setting. Patient who meet Level III criteria in dimensions 4, 5, and 6 and who otherwise would be placed in a Level III program may be considered for treatment in a Level II.5 program provided the adolescent resides in a home that provides 24-hour support and structure and that limits access to alcohol and other drugs. Mandatory support systems for Level II.5 include medical, laboratory and toxicology services available through consultation or referral. Psychiatric and medical consultation is available immediately by phone and within 24 hours for direct service to the youth. Emergency services are available 24 hours a day, seven days a week when the program is not in session and direct affiliation with more or less intensive levels of care. Beyond the essential services, many Level II.5 programs provide psychopharmacological assessment and treatment and the capacity to effectively treat adolescents who have complex co-occurring mental and substance-related disorders, and who can benefit from a therapeutic family setting.

**DIAGNOSTIC ADMISSION CRITERIA:**
- The adolescent who is appropriately placed at a Level II.5 program for substance abuse treatment is assessed as meeting the diagnostic criteria for a Substance Related disorder or a co-occurring psychiatric disorder as defined in the Diagnostic and Statistical Manual for Mental Disorders DSM IV (or current version).
- If the adolescent's presenting alcohol or other drug history is inadequate to substantiate such a diagnosis, the probability of such diagnosis may be determined from the information of collateral parties, i.e., parents, caregivers, guardians.
- Direct admission to a Level II.5 program is advisable for the adolescent who meets stability specifications in Dimensions 1 and 2 as well as the severity specifications of one of the Dimensions 1, 3, 4, 5, 6.
- Transfer to a Level II.5 program is advisable for the adolescent who has meet the treatment objectives at a more intensive level of care and who requires the intensity of services provided in a Level II.5 in at least one dimension.
- An adolescent also may be transferred to a Level II.5 from a Level I or a Level II.1 program when services provided at those levels have proved insufficient to address the adolescent's needs when Level I or Level II.1 services have consisted of motivational interventions to prepare the adolescent for participation in more intensive levels of care for which he or she now meets admission criteria.
- Continued stay is determined by reassessment of admission criteria and response to treatment.
- The following six dimensions are criteria that are abbreviated. **Providers are responsible to refer to the ASAM PPC-2R (or current version) Adolescent Placement Manual for more information.**

- **DIMENSION 1 ACUTE INTOXICATION AND/OR WITHDRAWAL:** The adolescent appropriately placed in a Level II.5 is:
  - Experiencing acute or subacute withdrawal marked by mild symptoms that are diminishing.
  - The adolescent is likely to attend, engage and participate in treatment as evidenced by the following:
    - The youth is able to tolerate mild withdrawal symptoms;
    - The youth has made a commitment to sustain treatment and to follow treatment recommendations; and
    - The youth has external supports as from family and/or court that promote treatment engagement.

- **DIMENSION 2 BIO-MEDICAL CONDITIONS AND COMPLICATIONS:** The adolescent appropriately placed in a Level II.5 is characterized by:
  - The adolescent’s biomedical conditions and problems are stable or are being concurrently addressed and will not interfere with treatment at this level of care;
• The adolescent’s biomedical conditions and problems are severe enough to distract from recovery and treatment at a lower level of care but will not interfere with recovery at Level II.5. The biomedical conditions and problems are being addressed concurrently by the medical treatment provider.

• **DIMENSION 3 EMOTIONAL, BEHAVIORAL OR COGNITIVE CONDITIONS AND COMPLICATIONS:** The adolescent’s status at Dimension 3 is characterized by one of the following:
  - Dangerousness/lethality - The adolescent is at mild risk of behaviors endangering self, others or property and requires frequent monitoring to assure reasonable likelihood of safety during each 24 hours. However, his or her condition is not severe to require 24-hour, awake supervision.
  - Interface with addiction recovery efforts - The adolescent’s recovery efforts are negatively affected by emotional, behavioral or cognitive problem which causes moderate interference with and requires increased intensity to support treatment participation and/or compliance.
  - Social functioning - The adolescent’s symptoms are causing mild to moderate difficulty in social functioning but not to such a degree that the adolescent is unable to manage the activities of daily living or to fulfill responsibilities at home, school, work or community. Alternatively, the adolescent may be transitioning back to the community in a step-down from an institutional setting.
  - Ability for self-care - The adolescent is experiencing moderate impairment in the ability to manage activities of daily living and thus requires near daily monitoring and treatment interventions. Problems may involve disorganization and inability to manage the demands of daily self-scheduling, a progressive pattern of promiscuous or unprotected sexual contacts, or poor vocational or pre-vocational skills that require habilitation and training provided by the program.
  - Course of illness - The adolescent’s history and present situation suggest that an emotional, behavioral, or cognitive condition would become unstable without daily or near daily monitoring and maintenance.

• **DIMENSION 4 READINESS TO CHANGE:** The adolescent status is characterized by:
  - The adolescent requires structured therapy and programmatic milieu to promote progress through the stages of change as evidenced by the following:
    - The adolescent demonstrates verbal and behavioral opposition to treatment,
    - The adolescent is only minimally involved in treatment,
    - The adolescent demonstrates poor compliance with attendance at outpatient sessions, or
    - The adolescent’s alcohol and drug use is escalating, contributing to school failure, truancy or behaviors leading to suspension from school.
  - The adolescent’s perspective and lack of impulse control inhibits the adolescent’s ability to make progress through stages of change. The adolescent thus requires structured therapy and a programmatic milieu. Such interventions are not feasible or likely to succeed in a Level II.1 service. However, the adolescent's resistiveness is not so high as to render treatment ineffective.

• **DIMENSION 5 RELAPSE, CONTINUED USE OR CONTINUED PROBLEM POTENTIAL:** The adolescent’s status in Dimension 5 is characterized by the following:
  - The adolescent is at high risk of relapse or continued use without almost daily outpatient monitoring and structured therapeutic services. Treatment at a less intensive level of care has been attempted or given serious consideration and has been judged insufficient to stabilize the adolescent’s condition.
  - The adolescent demonstrates impaired recognition and understanding of relapse issues. The adolescent has such poor skills in coping with and interrupting substance use problems and avoiding or limiting relapse that the near daily structure
afforded by Level II.5 is needed to prevent or arrest significant deterioration in function.

- **DIMENSION 6 RECOVERY ENVIRONMENT:** The adolescent's status in Dimension 6 is characterized by:
  - Continued exposure to the adolescent’s current school, work or living environment will render recovery unlikely. The adolescent lacks the resources or skills necessary to maintain an adequate level of functioning without the services of a Level II.5 program.
  - The adolescent is capable of maintaining an adequate level of functioning between sessions.
  - The adolescent lacks social contacts or has inappropriate social contacts that jeopardize recovery or has few friends or peers who do not use alcohol or drugs. The adolescent has insufficient resources or skills necessary to maintain an adequate level of functioning without the services of Level II.5 program but is capable of maintaining an adequate level of functioning between sessions.
  - Family members and/or significant others living with the adolescent are not supportive of his or her recovery goals and/or are passively opposed to treatment. The adolescent requires structured treatment services and relief from the home environment in order to remain focused on recovery but he or she may live at home because there is active opposition to or sabotaging of the recovery effort.

**Discharge/Transfer Criteria**

It is appropriate to transfer or discharge the adolescent from the present level of care if he or she meets the following criteria:

1. The adolescent has achieved the goals articulated in his or her individualized treatment plan thus resolving the problem(s) that justified admission to the present level of care and has a comprehensive relapse plan in place which addresses his/her specific needs.  
   OR
2. The adolescent has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan. Treatment at another level of care or type of service is therefore indicated.  
   OR
3. The adolescent has demonstrated a lack of capacity to resolve his or her problem(s). Treatment at another level of care or type of service is therefore indicated.  
   OR
4. The adolescent has experienced an intensification of his or her problem(s), or has developed a new problem(s), and can be treated effectively only at a more intensive level of care.

To document and communicate the adolescent’s readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the existing or new problem(s), the adolescent should be discharged or transferred, as appropriate.

(8-1-08)
TREATMENT GROUP HOME SUBSTANCE ABUSE TREATMENT (ASAM LEVEL III.1:
CLINICALLY MANAGED LOW-INTENSITY RESIDENTIAL TREATMENT)

For Nebraska Medicaid enrolled providers of treatment services, this subchapter applies to managed care enrolled providers of Treatment Group Home (TGH). Providers will need to adhere to the regulations and program descriptions of the Nebraska Medical Assistance Program (NMAP) Chapter 32 (471 NAC 32-006 Treatment Group Home Services) (TGH) and the Medicaid Managed Care Program description for treatment group home services as described in the Managed Care Handbook Supplement, Appendix B.

- The following is based on the Adolescent Criteria of the Patient Placement Criteria for the treatment of Substance Related Disorders of the American Society of Addiction Medicine, Second Edition Revised (ASAM PPC-2R or current version) pages 235-269. Providers are responsible to refer to the ASAM PPC-2R Adolescent Placement Manual for complete criteria.

SERVICES: Adolescent Level III.1 programs offer organized treatment services that feature a planned regimen of care in a 24-hour community treatment environment that is currently licensed in Nebraska as a Substance Abuse Treatment Center. These programs may also be licensed as a Mental Health Center. Treatment services adhere to defined policies, procedures and clinical protocols. Services are provided in permanent facilities where youth can reside safely with structure and support and have an opportunity to develop and practice their interpersonal and group living skills, strengthen their recovery skills, reintegrate into the community and possibly family, and find or return to school or vocational training. The programs are staffed 24 hours/day to provide structure and supervision. The services provided must include individual, group and family therapy; medication management and medication education. Mutual/self-help meetings usually are available on site or are arranged and provided in the community. Some youth require the structure of a Level III.1 program to achieve engagement in treatment. Those who are in the early stages of readiness to change may need to be removed from an unsupportive living environment in order to minimize their continued alcohol or other drug use. Level III.1 programs can also meet the needs of individuals who may not yet acknowledge that they have an alcohol or other drug problem. Such individuals may be living in a recovery environment that is too toxic to permit treatment on an outpatient basis. Because these youth are in the early stage of readiness to change, they may need a setting that provides 24-hour structure, supervision and support and provides motivating strategies to prevent deterioration, engage in treatment and facilitate the youth's progress through the stages of change to recovery. The youth and youth's family/caregiver/guardian should be involved in planning continuing care to support recovery and improve his or her functioning.

DETOXIFICATION SERVICES: Providers are referred to Level IV Acute Inpatient Hospital Detoxification Services (Med-Surg), for Medically Managed Intensive Inpatient Detoxification Services.

HOURS: Hours of operation (supervision, structure and treatment) are 24 hours per day with a minimum of 21 structured hours of treatment and recovery focused services per week.

STAFFING: Staff in Level III.1 programs must be comprised of clinical staff and allied professional staff. A Program Director is responsible for clinical supervision of the day-to-day treatment and of treatment staff who are educated and trained in the treatment of mental health substance abuse disorders. The Program Director relates to the supervising practitioner who supervises and directs all clinical interventions. One or more clinicians with competence in the treatment of substance dependence disorders are available on-site or by telephone 24 hours a day and one or more licensed clinicians are on-site during treatment program delivery.
Licensed alcohol and drug counselors and mental health clinicians provide direct counseling. Clinical staff is knowledgeable about the biological and psychosocial dimensions of substance dependence and mental health disorders and their treatment, and are able to identify the signs and symptoms of acute psychiatric conditions including psychiatric decompensation. Dually licensed staff must provide counseling services to those youth who have significant acuity in both mental health and substance abuse issues. Staff have specialized training in behavior management techniques. Allied health professional staff, such as counselor aides and direct care staff are on-site and available 24 hours a day as required by program policy and licensing regulations. Allied health professionals shall have a bachelor's degree or post-high school education and training in substance abuse addictions, psychology, or related fields or 2 years experience in delivery of substance abuse services or related area or demonstrated skill and competency to work with youth with chronic substance dependence. Appropriately trained staff is available to dispense medications or to supervise the self-administration of medications.

**THERAPIES:** Therapies offered by Level III.1 programs include:

- Supervision and structure designed to promote abstinence and improve the youth's ability to structure and organize the tasks of daily living and recovery, such as personal responsibility, personal appearance and punctuality and sustain participation in concurrent treatment services or daily activities such as school or work.
- Twenty-one hours of planned clinical program activities designed to foster group living skills, develop and apply recovery skills and promote development of a social network supportive of recovery in successful reintegration into the community, stabilize and maintain the stability of the youth's substance dependence symptoms and help him or her develop and apply recovery skills. In addition to individual, family and group counseling and psychoeducational groups, treatment activities may include relapse prevention, medication education, recreational activity, and other occupational and skill-building activities.
- Random drug screening to shape behavior and reinforce treatment gains, as appropriate to the youth's individual treatment plan.
- Motivational enhancement and engagement strategies appropriate to the youth's stage of readiness to change, which are used in preference to confrontational approaches.
- Regular monitoring of the youth's compliance for taking any prescribed medications as appropriate.
- Services also involve the youth's family/caregiver/guardian and significant others, as appropriate.

**ASSESSMENT/TREATMENT PLAN:** In Level III.1 programs, the assessment and treatment plan review include:

- An individualized, comprehensive biopsychosocial assessment of the youth’s substance dependence disorder and mental health problems conducted by or updated by clinicians who are knowledgeable about addiction and mental health treatment and support the appropriateness of placement at Level III.1 and help guide the individualized treatment planning process.
- Initial diagnostic interview provided by the program's supervising practitioner (psychiatrist or psychologist).
- A physical examination by a physician and additional medical interventions as determined by the youth’s medical condition.
- The individualized treatment plan which is formulated and updated at specified intervals and contains documentation of the adolescent's clinical problems. The treatment team identifies short-term, measurable treatment goals and objectives and planned interventions designed to achieve those goals. The plan is developed in collaboration with the youth and the youth’s family and reflects the youth’s personal goals.
- The treatment plan reflects case management conducted by treatment team staff; coordination of related addiction treatment, health care, mental health, and social,
vocational or housing services (provided concurrently); and the integration of services at this and other levels of care.

- The treatment plan and updates and daily progress notes that reflect the youth’s clinical progress, as reviewed by an interdisciplinary treatment team, directly supervised by the supervising practitioner.
- Progress notes for counseling and therapy services that fully discloses the specific intervention and the youth’s response to the intervention.
- The treatment plan is reviewed in collaboration with the youth and youth's family/caregiver/guardian every 30 days and documented accordingly.

**LENGTH OF STAY:** While the duration of treatment varies with the severity of a youth's illness and his or her response to treatment, the length of service in clinically managed Level III.1 programs tend to be longer than in the more intensive medically monitored and medically managed levels of care. Some youth may enter Level III.1 programs under a court order that specifies their length of stay.

*However, treatment professionals have a responsibility to make admission, continued service and discharge decisions based on their own clinical impressions of a youth's assessed need and treatment progress. Thus, if a youth has improved sufficiently to warrant discharge or transfer, the treatment professionals have a responsibility to contact the appropriate court and seek to have the court order amended.*

**DOCUMENTATION:** Level III.1 program clinical records must include the mental health substance abuse assessment documents (pretreatment assessment) and treatment plans as well as updates of the plan. Individualized progress notes for each service must be organized in the youth’s record, and clearly reflect implementation of the treatment plan and the youth’s response to the therapeutic interventions for all disorders treated. Documentation must support that a Master Treatment Plan is completed within 7 days of admission and concurrent reviews are conducted in collaboration with the youth, his/her family/caregiver/guardian, and recorded every 30 days. The clinical record must contain other essential treatment documents which include but are not limited to all other assessments, orders and progress notes of the supervising practitioner, nursing notes, other related medical reports, lab results, medication management records as well as appropriately signed consent forms.

**SUPPORT SYSTEMS:** For Level III.1 Adolescent Programs, necessary support systems include:

- The availability of the supervising practitioner at times of emergency by telephone or in person to respond to the emergency and consult with the treatment program director or appropriate licensed clinician. Psychological services, nursing services and emergency services are available 24 hours a day, 7 days a week.
- The program is able to arrange for appropriate medical procedures (including indicated laboratory and toxicology testing) as appropriate to the severity and urgency of the youth’s condition.
- Availability to support and coordinate the adolescent access to school, work and concurrent treatment service.
- Direct affiliation with other levels of care.

**DIAGNOSTIC ADMISSION CRITERIA:**

- The youth who is appropriately placed in a Level III.1 program meets the diagnostic criteria for a Substance Dependence Disorder, as defined in the current DSM IV (or current version), or other standardized and widely accepted criteria, as well as the dimension criteria for admission.
- Continued stay reviews are provided to reassess the medical need at specified intervals to determine progress and appropriateness of ongoing treatment at this level.
The youth who is appropriately admitted to a Level III.1 program meets specifications in two dimensions, one through six.

The following six dimensions and criteria are abbreviated. Providers are responsible to refer to the ASAM PPC-2R ADOLESCENT PLACEMENT MANUAL for the complete criteria.

**DIMENSION 1: ACUTE INTOXICATION AND/OR WITHDRAWAL POTENTIAL:**
The adolescent's status in dimension 1 is characterized by the following:
- Problems with intoxication or withdrawal that are managed through concurrent placement at another level of care for detoxification (typically Level I, Level II.1 or Level II.5).
- If residential treatment in a Level III.1 program is being used to support detoxification at the non-residential level of care, then the adolescent is considered to have met specifications in Dimension 1.

**DIMENSION 2: BIOMEDICAL CONDITIONS AND COMPLICATIONS:**
The adolescent's status in Dimension 2 is characterized by one of the following:
- Biomedical conditions distract from recovery efforts and require limited residential supervision to ensure their adequate treatment or provide support to overcome distraction. Adequate nursing and medical monitoring is provided as a mandatory service at this level of care.
- Continued substance use would place the youth at risk of serious damage to his or her physical health because of a biomedical condition an imminent dangerous pattern of high risk use. Adequate nursing or medical monitoring for biomedical conditions can be provided through an arrangement with another provider. The adolescent accepts prescribed medications and/or health care procedures.

**DIMENSION 3: EMOTIONAL, BEHAVIORAL OR COGNITIVE CONDITIONS AND COMPLICATIONS:**
The adolescent's status is characterized by one of the following requiring 24-hour supervision:
- Dangerousness/Lethality--The adolescent is at risk for dangerous consequences because of a lack of stable living environment. The youth needs a stable residential setting for protection.
- Interference with Addiction Recovery Efforts--The adolescent needs a stable living environment to promote a sustained focus on recovery tasks.
- Social Functioning--The adolescent's emotional, behavioral or cognitive problems result in moderate impairment in social functioning. The youth needs limited 24-hour supervision which can be provided by the program staff.
- Ability for Self-Care--The adolescent has moderate impairment in his or her ability to manage the activities of daily living and thus needs 24-hour supervision which can be provided by program staff.
- Course of Illness--The adolescent's history and present situation suggest that an emotional, behavioral or cognitive condition would become unstable without 24-hour supervision or the adolescent's emotional, behavioral or cognitive condition suggests the need for low intensity and/or longer term reinforcement and practice of recovery skills in a controlled environment.

**DIMENSION 4: READINESS TO CHANGE:**
The adolescent status in a Level III.1 is characterized by:
- The adolescent is open to recovery, but requires a 24-hour environment and supervision to promote and sustain progress through stages of change.
- The adolescent is cooperative and likely to engage in treatment at this level of care.
• **DIMENSION 5: RELAPSE, CONTINUED USE OR CONTINUED PROBLEM POTENTIAL:** The adolescent's status is characterized by one of the following requiring low intensity 24-hour supervision to prevent relapse or attenuate continued use:
  - Lack of monitoring or supervision between treatment encounters at a less intensive level of care has been a major barrier to abstinence
  - The adolescent's recovery skills is not yet sufficient to overcome environmental triggers, such as peer substance use, or internal triggers such as cravings.
  - The adolescent's history of chronic substance abuse, repeated relapse and/or treatment resistance predicts continued use or relapse without a residential treatment environment.

• **DIMENSION 6: RECOVERY ENVIRONMENT:** The adolescent's status is characterized by one of the following:
  - The adolescent has been living in an environment in which there is a high risk of neglect or initiation or repetition of physical, sexual or severe emotional abuse, such that the adolescent is assessed as being unable to achieve or maintain recovery without residential containment; or
  - The adolescent has family or other household member who has an active substance use disorder or substance use is endemic in his or her home environment or broader social network so that recovery goals are assessed as unachievable without residential containment.
  - The adolescent's home environment or social network is too chaotic or ineffective to support or sustain treatment goals so that recovery is assessed as unachievable without residential support.
  - Logistical impediments such as distance from treatment facility, mobility limitations, lack of transportation and the like preclude participation in treatment at a less intensive level of care.

**Discharge/Transfer Criteria**

It is appropriate to transfer or discharge the adolescent from the present level of care if he or she meets the following criteria:

1. The adolescent has achieved the goals articulated in his or her individualized treatment plan thus resolving the problem(s) that justified admission to the present level of care and has a comprehensive relapse plan in place that meets the individual needs of the adolescent.
   
   OR

2. The adolescent has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan. Treatment at another level of care or type of service is therefore indicated.
   
   OR

3. The adolescent has demonstrated a lack of capacity to resolve his or her problem(s). Treatment at another level of care or type of service is therefore indicated.
   
   OR

4. The adolescent has experienced an intensification of his or her problem(s), or has developed a new problem(s), and can be treated effectively only at a more intensive level of care.

To document and communicate the adolescent's readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the existing or new problem(s), the adolescent should be discharged or transferred, as appropriate.

(8-1-08)
ENHANCED TREATMENT GROUP HOME SUBSTANCE ABUSE TREATMENT (ASAM
LEVEL: III.1 CLINICALLY MANAGED LOW-INTENSITY RESIDENTIAL TREATMENT
SERVICES DEFINITION

For Nebraska Medicaid enrolled providers, this subchapter applies to managed care enrolled Enhanced Treatment Group Home (ETGH) services. Providers of ETGH need to adhere to the regulations and service definitions as described in the Medicaid Managed Care Handbook Supplement, Appendix B, for Enhanced Treatment Group Home services.

- The following is based on the Adolescent Criteria of the Patient Placement Criteria for the treatment of Substance Related Disorders of the American Society of Addiction Medicine, Second Edition Revised (ASAM PPC-2R, or current version) pages 235-269. Providers are responsible to refer to the ASAM PPC-2R Adolescent Placement Manual for complete criteria.

SERVICES: Level III.1 programs must be offered in an appropriately licensed Nebraska Substance Abuse Treatment Center. This center must be located in a community setting and may also be licensed as a Mental Health Treatment Center. Level III.1 programs are designed to provide sub-acute treatment that aims to affect fundamental personal change for adolescents who have significant social and psychological problems. Such programs are characterized by their reliance on the treatment community and treatment milieu as a therapeutic agent. The goals of treatment are to promote abstinence from substance use and antisocial behavior and treatment of any other mental health problem and to effect a global change in participants’ lifestyles, attitudes and values. This philosophy views substance-related problems as disorders of the whole youth that are reflected in problems with conduct, attitudes, moods, values, and emotional management. It is intended that the youth be introduced into a healthy peer group with the ability to form group identity that emphasizes recovery, and overcoming adversity as a treatment expectation. The defined characteristics of these youth are found in their emotional, behavioral and cognitive conditions and their living environments.

Youth who are appropriately placed in this Level III.1 program typically have multiple deficits, which may include substance-related disorders, criminal activity, psychological problems, and impaired functioning and are entrenched in patterns of maladaptive behaviors, extremes of temperament and developmental or cognitive abnormalities related to mental health disorders. Their mental disorders may involve disruptive behaviors, delinquency, educational difficulties, family conflict, chaotic home situations, developmental immaturity and other psychological problems. Mental disorders may also involve serious mental health issues. Poor social skills, inadequate anger management skills, extreme impulsivity, emotional immaturity and /or an antisocial value system are often characteristic.

DETOXIFICATION SERVICES: Providers are referred to Level IV Acute Inpatient Hospital Detoxification Services in an Acute Care Hospital (med-surg), for medically managed intensive inpatient detoxification services.

HOURS: Enhanced Treatment Group Homes having Level III.1 services operate 24 hours per day, seven days per week of structured, organized therapeutic milieu services with 21 hours per week of structured treatment services. A minimum of 16 cognitive behavioral interventions per day are provided by trained and skilled staff functioning in an organized treatment environment.

STAFFING: Minimum staffing requirements are as follows: 1:3 overall direct care staff to youth during waking hours, 1:6 during sleeping hours, and 1:12 therapist to youth ratio. Adequately trained staff must be available in numbers sufficient to provide at a minimum of 16 cognitive behavioral interventions per day in an organized environment. Staffing numbers are expected to appropriately address the acuity of the youth being served and the program must provide sufficient staff to provide safety and treatment when crisis situations occur.
STAFFING: Program staffing is comprised of clinical professional staff and paraprofessional staff under the clinical supervision of a physician who has a specialty in psychiatry or a fully licensed Ph.D. (psychologist). Program/Clinical Director is responsible for clinical supervision under the direction of a supervising practitioner. Clinical, professional staff provide individual, group and family therapy, medication education, and are knowledgeable and can identify the biological and psychosocial dimensions of substance dependence and mental health disorders and their treatment. Clinical professional staff is expected to be competent to identify the signs and symptoms of acute psychiatric conditions including psychiatric decompensation in addition to the substance abuse behaviors. Staff have specialized training in behavioral management techniques and normal child and adolescent growth and development.

Direct care staff (paraprofessionals) are on-site and available 24 hours a day as required by Medicaid regulations and licensing requirements. Sixty-seven percent of direct care staff shall have a bachelor's degree or four years of experience in the human services field. Post-high school education/degree in substance addictions, psychology, or related fields is preferable. Direct care staff (paraprofessionals) must have completed the program's initial training and must have demonstrated skills and competency to work with youth with serious substance dependence and mental health issues. Direct care staff must have clinical professional staff available for supervision and consultation in emergency situations at all times.

THERAPIES: Therapies offered by this Level III.1 program (enhanced treatment group homes) include:

- A structured therapeutic milieu in which behavior modification techniques are used to foster group living skills and an atmosphere of individual participation in the community of recovery.
- Trained clinical staff to provide services, adapted to the adolescent's developmental and cognitive level, to assess and address the adolescent's individual needs. Such services encompass individual and group counseling, psychotherapy, family therapy, psychoeducational services, low intensity medical treatment, psychiatric treatment, expressive therapies, occupational or recreational activities, vocational rehabilitation services and the like.
- Planned clinical program activities that are designed to develop and apply recovery skills, (including relapse prevention) promote development of a social network supportive of recovery, reinforce pro-social values, enhance the adolescent's understanding of addiction, promote successful involvement in regular, productive daily activities (such as school or work), enhance personal responsibility and developmental maturity and, as indicated, promote successful reintegration into community living.
- Family therapy involves significant family members or guardians in the assessment, treatment and continuing care of the adolescent.
- Educational services are provided in accordance with local regulations (typically on-site) and are designed to maintain the educational and intellectual development of the adolescent and, when indicated, to provide opportunities to remedy deficits in the educational level of adolescents who have fallen behind because of their involvement in alcohol and other drugs.
- Random drug screening used to reshape behaviors and reinforce treatment gains as medically appropriate to the adolescent's individualized treatment plan.
- For productive daily living.
- Medication education must be provided by an appropriately licensed professional, registered nurse or a physician.

ASSESSMENT/TREATMENT PLAN: In this Level III.1 program, the assessment and treatment plan review includes:

- An individualized, comprehensive biopsychosocial assessment of the youth's substance abuse and mental health symptoms, problems and dysfunctions conducted
by or updated by licensed clinicians who have sufficient expertise in addiction and mental health treatment.

- An initial diagnostic interview by a supervising practitioner (psychologist or psychiatrist) to determine and develop diagnosis as appropriate and to confirm the appropriateness of treatment at Level III.1 and to help guide the treatment planning process.
- A physical examination performed by a physician immediately before or at the time of admission as determined by the youth’s medical condition.
- An individualized treatment plan, which includes problem formulation and articulation of short-term, measurable treatment goals and activities, designed to achieve those goals. The plan is developed in collaboration with the youth and reflects the youth’s personal goals. The initial treatment plan is developed within 24 hours of admission and concurrent reviews are conducted every 7 days.
- The treatment plan reflects case management conducted by on-site staff; coordination of related addiction treatment, health care, mental health, and social, vocational or housing services (provided concurrently); and the integration of services at this and other levels of care.

LENGTH OF STAY: While the duration of treatment varies with the severity of a youth's illness and the youth's response to treatment, the length of service in this clinically managed Level III.1 program tends to be longer than the more intensive medically monitored and managed levels of care. Some youth enter level III.1 programs under court order that specifies their level of stay.

However, treatment professionals have a responsibility to make admission, continued service and discharge decisions based on their own clinical impressions of an individual's assessed need and treatment progress. Thus, if a youth has improved sufficiently to warrant discharge or transfer, the treatment professional has a responsibility to contact the appropriate court and seek to have the court order amended.

DOCUMENTATION: In Level III.1 programs, documentation must include a comprehensive assessment, which includes a biopsychosocial assessment, particularly addressing the substance abuse and mental health issues. An initial diagnostic interview by a psychiatrist or psychologist is needed. Individualized progress goals in the youth’s record must clearly reflect implementation of the individualized treatment plan. A master treatment plan must be included in the clinical documentation as well as subsequent amendments to the plan. Treatment plan reviews appropriately reflect ASAM Patient Placement Criteria. Each treatment service is summarized in an individual progress note and the clinical record must contain daily progress notes summarizing treatment and the youth's response.

SUPPORT SYSTEMS: For Level III.1 Adolescent Programs, necessary support systems include:

- The supervising practitioner is available 24 hours a day, seven days a week in person or by phone. A psychologist or psychiatrist who serves as a supervising practitioner directs and supervises the individualized treatment plan of the youth in the program.
- Ability to arrange for appropriate medical procedures, including but not limited to, indicated laboratory and toxicology testing, dental services and other diagnostic and treatment services.
- Ability to arrange appropriate medical and psychiatric treatment through referral or transfer to another level of care in emergency situations.
- Direct affiliation with other levels of care.

DIAGNOSTIC ADMISSION CRITERIA:

- The youth who is appropriately placed in a Level III.1 program meets the diagnostic criteria for a Substance Dependence Disorder, as defined in the current DSM IV (or current
version), or other standardized and widely accepted criteria, as well as the dimension criteria for admission.

- Continued stay reviews are provided to reassess the medical need at specified intervals to determine progress and appropriateness of ongoing treatment at this level.
- The youth who is appropriately admitted to a Level III.1 program meets specifications in two dimensions, one through six.
- The following six dimensions and criteria are abbreviated. Providers are responsible to refer to the ASAM PPC-2R ADOLESCENT PLACEMENT MANUAL for the complete criteria.

**DIMENSION 1: ACUTE INTOXICATION AND/OR WITHDRAWAL POTENTIAL:** The adolescent's status in dimension 1 is characterized by the following:

- Problems with intoxication or withdrawal that are managed through concurrent placement at another level of care for detoxification (typically Level I, Level II.1 or Level II.5).
- If residential treatment in a Level III.1 program is being used to support detoxification at the non-residential level of care, then the adolescent is considered to have met specifications in Dimension 1.

**DIMENSION 2: BIOMEDICAL CONDITIONS AND COMPLICATIONS:** The adolescent's status in Dimension 2 is characterized by one of the following:

- Biomedical conditions distract from recovery efforts and require limited residential supervision to ensure their adequate treatment or provide support to overcome distraction. Adequate nursing and medical monitoring is provided as a mandatory service at this level of care.
- Continued substance use would place the youth at risk of serious damage to his or her physical health because of a biomedical condition an imminent dangerous pattern of high risk use. Adequate nursing or medical monitoring for biomedical conditions can be provided through an arrangement with another provider. The adolescent accepts prescribed medications and/or health care procedures.

**DIMENSION 3: EMOTIONAL, BEHAVIORAL OR COGNITIVE CONDITIONS AND COMPLICATIONS:** The adolescent's status is characterized by one of the following requiring 24-hour supervision:

- Dangerousness/Lethality--The adolescent is at risk for dangerous consequences because of a lack of stable living environment. The youth needs a stable residential setting for protection.
- Interference with Addiction Recovery Efforts--The adolescent needs a stable living environment to promote a sustained focus on recovery tasks.
- Social Functioning--The adolescent's emotional, behavioral or cognitive problems result in moderate impairment in social functioning. The youth needs limited 24-hour supervision which can be provided by the program staff.
- Ability for Self-Care--The adolescent has moderate impairment in his or her ability to manage the activities of daily living and thus needs 24-hour supervision which can be provided by program staff.
- Course of Illness--The adolescent's history and present situation suggest that an emotional, behavioral or cognitive condition would become unstable without 24-hour supervision or the adolescent's emotional, behavioral or cognitive condition suggests the need for low intensity and/or longer term reinforcement and practice of recovery skills in a controlled environment.

**DIMENSION 4: READINESS TO CHANGE:** The adolescent status in a Level III.1 is characterized by:
• The adolescent is open to recovery, but requires a 24-hour environment and supervision to promote and sustain progress through stages of change.
• The adolescent is cooperative and likely to engage in treatment at this level of care.

**DIMENSION 5: RELAPSE, CONTINUED USE OR CONTINUED PROBLEM POTENTIAL:** The adolescent's status is characterized by one of the following requiring low intensity 24-hour supervision to prevent relapse or attenuate continued use:
• Lack of monitoring or supervision between treatment encounters at a less intensive level of care has been a major barrier to abstinence
• The adolescent's recovery skills are not yet sufficient to overcome environmental triggers, such as peer substance use, or internal triggers such as cravings.
• The adolescent's history of chronic substance abuse, repeated relapse and/or treatment resistance predicts continued use or relapse without a residential treatment environment.

**DIMENSION 6: RECOVERY ENVIRONMENT:** The adolescent's status is characterized by one of the following:
• The adolescent has been living in an environment in which there is a high risk of neglect or initiation or repetition of physical, sexual or severe emotional abuse, such that the adolescent is assessed as being unable to achieve or maintain recovery without residential containment; or
• The adolescent has family or other household member who has an active substance use disorder or substance use is endemic in his or her home environment or broader social network so that recovery goals are assessed as unachievable without residential containment.
• The adolescent's home environment or social network is too chaotic or ineffective to support or sustain treatment goals so that recovery is assessed as unachievable without residential support.
• Logistical impediments such as distance from treatment facility, mobility limitations, lack of transportation and the like preclude participation in treatment at a less intensive level of care.

**Discharge/Transfer Criteria**
It is appropriate to transfer or discharge the adolescent from the present level of care if he or she meets the following criteria:

1. The adolescent has achieved the goals articulated in his or her individualized treatment plan thus resolving the problem(s) that justified admission to the present level of care and has a comprehensive relapse plan in place that meets the individual needs of the adolescent.
   OR
2. The adolescent has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan. Treatment at another level of care or type of service is therefore indicated.
   OR
3. The adolescent has demonstrated a lack of capacity to resolve his or her problem(s). Treatment at another level of care or type of service is therefore indicated.
   OR
4. The adolescent has experienced an intensification of his or her problem(s), or has developed a new problem(s), and can be treated effectively only at a more intensive level of care.

To document and communicate the adolescent's readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the existing or new problem(s), the adolescent should be discharged or transferred, as appropriate.

(8-1-08)
RESIDENTIAL TREATMENT CENTER SUBSTANCE ABUSE TREATMENT (ASAM LEVEL III.5: CLINICALLY MANAGED MEDIUM-INTENSITY RESIDENTIAL TREATMENT)

For Nebraska Medicaid enrolled providers of treatment services, this subchapter applies to enrolled Residential Treatment Centers. Providers of Residential Treatment Centers must adhere to the regulations and program descriptions of the Nebraska Medical Assistance Program (NMAP), Chapter 32 (471 NAC 32-007 Residential Treatment Centers) and the Medicaid Managed Care Handbook Supplement, Appendix B, description for Residential Treatment Centers.

- The following is based on the Adolescent Criteria of the Patient Placement Criteria for the treatment of substance related disorders of the American Society of Addiction Medicine, Second Edition Revised (ASAM PPC-2R or current version) pages 235-269. Providers are responsible to refer to the ASAM PPC-2R Adolescent Placement Manual for complete criteria.

SERVICES: Level III.5 programs are organized, professionally directed treatment services that feature a planned regimen of treatment and care in a 24 hour setting that is currently licensed in Nebraska as a Substance Abuse Treatment Center. The facility may also have acquired additional licensure for a mental health center or for a hospital. Professionally directed services include evaluation, observation, medical monitoring, substance abuse and mental health treatment in an inpatient setting. Level III.5 programs may be located in community facilities or a specialty unit of a hospital with acute psychiatric inpatient beds. The program functions under a defined set of policies, procedures and clinical protocols. Level III.5 programs are appropriate for youth whose subacute biomedical and emotional, behavioral or cognitive problems are so severe that they require inpatient treatment, but do not need the full resources of an acute care general hospital for detoxification or a medically managed inpatient treatment program, or a psychiatric hospital.

The services of a Level III.5 program are designed to meet the needs of youth who have functional deficits related to withdrawal risk, biomedical conditions and/or complications, or emotional, behavioral, or cognitive conditions and complications. These medically monitored services are provided under the supervision of a physician with a specialty in psychiatry and training and/or experience in addiction medicine. The program operates under a medical model. The adolescent who is appropriately placed in a medically monitored program may have problems in the areas mentioned earlier that require medical or nursing services. Alternatively, the youth may have problems that do not so much require direct medical or nursing services as the overall high intensity of a program and treatment milieu that draws on the staffing pattern and availability of interdisciplinary professional team that characterize medically monitored programs. An interdisciplinary team of appropriately credentialed treatment professionals, including psychiatrists who are trained to assess and treat substance abuse disorders deliver the care provided in Level III.5 programs. Level III.5 programs employ a program director/manager who is fully and duly licensed to provide leadership, management and supervision of all staff and treatment services. Treatment is specific to substance-related disorders, but the skills of the interdisciplinary team and the availability of support services also can accommodate detoxification and/or intensive inpatient treatment of addiction and/or conjoint treatment of co-occurring subacute biomedical and/or emotional, behavioral or cognitive conditions.

DETOXIFICATION SERVICES: Providers are referred to Level IV Acute Inpatient Hospital Detoxification Services for medically managed intensive inpatient detoxification services (med-surg).
HOURS: Level III.5 programs must operate 24 hours per day and provide 42 hours per week of structured treatment services and recovery focused services. The length of the service is determined by the progress of each individual youth and by the individualized treatment plans.

STAFFING: Minimum staffing requirements are as follows: 1:4 overall direct care staff during waking hours, 1:6 overall direct care staff during sleeping hours, and 1:8 youth to therapist ratio. These are minimum requirements. However, staffing is expected to appropriately address the acuity of the youth being served. The program must have a plan to involve additional staff and expertise, when necessary, to meet the clinical needs of the youth being served.

Level III.5 programs are staffed by:
- An interdisciplinary team including a psychiatrist who functions as the supervising practitioner, physicians for medical care, appropriately trained nurses for nursing intervention, appropriately trained dual licensed clinicians for addiction services and mental health services in a dual approach and who have substance dependence orders are able to assess and intervene and provide treatment interventions for youth who have mental and substance abuse dependence disorder.
- Direct care staff is appropriately trained, skilled and competent to provide interventions within the milieu as determined by the treatment plan. Seventy-five percent of direct care staff (paraprofessionals) for residential treatment centers shall have a bachelor's degree or five years of experience in the human services field, post-high school education/degree in addictions or psychology or related field is preferable. The direct care staff must complete the initial training program and must demonstrate skill and competence to work with youth with serious substance dependence and mental health issues.
- Licensed clinical staff members are knowledgeable about the biological and psychosocial dimensions of substance dependence and mental health disorders and have training in behavior management techniques. Licensed clinical professional staff is able to provide a planned regimen of 24-hour professionally directed evaluation, care and treatment services, including administration of medications.

THERAPIES: Therapies offered by Level III.5 programs include:
- Daily clinical services provided by an interdisciplinary treatment team that assess and address the youth’s individual treatment needs.
- Planned clinical program activities to stabilize the acute addictive and/or non-medical or psychiatric symptoms. Treatment must include psychiatric services, pharmacological assessment and management, cognitive-behavioral and other therapies administered to the patient on an individual an/or group basis. Individual group and family therapy and psychoeducational services must be offered. Such activities are adapted to the youth’s developmental age and level of comprehension. Structured, scheduled treatment services must total 42 hours per week.
- Counseling and clinical monitoring to promote successful initial involvement or reinvolved in regular, productive daily activity, and, as indicated, successful reintegration into family living.
- Random drug screening to shape behavior and reinforce treatment gains, as appropriate to the youth’s individual treatment plan.
- Counseling and medical monitoring to teach the patient the skills needed for productive daily activity, as at work or school, and, as indicated, successful reintegration into family living.
- Regular monitoring of the youth’s compliance in taking any prescribed medications.
- Planned clinical program activities, designed to enhance the patient’s understanding of his or her substance dependence and/or mental disorder.
- Health education services also are provided.
- Clinical and didactic motivational interventions appropriate to the resident’s stage of readiness to change, and which are designed to facilitate the resident’s understanding of
the relationship between his or her substance dependence disorder and attendant life issues.

- Daily treatment services to manage acute symptoms of the patient's biomedical, substance dependence or mental disorder.
- Services which focus on the identified youth treatment needs are provided to the youth's family and significant others.

**ASSESSMENT/TREATMENT PLAN:** In Level III.5 programs, the assessment and treatment planning procedure must include:

- A comprehensive biopsychosocial assessment of the adolescent’s substance dependence disorder and mental health problem(s), conducted or updated by staff who are knowledgeable about addiction and mental health treatment, who can support the appropriateness of placement at Level III.5 and guide the individual treatment planning process.
- An initial diagnostic interview by the psychiatrist within 24 hours of admission.
- A physical examination performed by a physician within 24 hours of admission or a review by a facility physician (within 24 hours of admission) of a physical examination conducted no more than 7 days prior to admission.
- A comprehensive nursing assessment performed at the time of admission.
- An individualized treatment plan, which includes problem formulation and articulation of short-term, measurable treatment goals and activities, designed to achieve those goals. The plan is developed in collaboration with the youth and reflects the youth’s personal goals. The initial treatment plan must be completed within 24 hours of admission and concurrent plans must be completed every 7 days thereafter.
- A comprehensive master treatment plan and treatment plan updates that reflect the youth’s clinical progress, as reviewed by the interdisciplinary treatment team, directed and supervised by the psychiatrist.
- A treatment plan reflects case management conducted by on-site staff; coordination of related addiction treatment, health care, mental health, social, vocational or housing services (provided concurrently); and the integration of services at this and other levels of care.

**LENGTH OF STAY:** The duration of treatment should always be determined by the progress of each individual patient. Just as treatment plans should be individualized, length of stay should be flexible and individualized to meet the needs of each adolescent.

*However, treatment professionals have a responsibility to make admission, continued service and discharge decisions based on their own clinical impressions of an individual’s assessed need and treatment progress. Thus, if a patient has improved sufficiently to warrant discharge or transfer, the treatment professional has a responsibility to contact the appropriate court and seek to have the court order amended.*

**DOCUMENTATION:** In Level III.5 programs documentation requirements include: a comprehensive assessment (biopsychosocial assessment and initial diagnostic interview), a comprehensive treatment plan and treatment plan updates, individual progress notes kept in the youth’s record that clearly reflect implementation of the treatment plan and the youth’s response to the treatment and therapeutic interventions for all disorders treated. The treatment plan (including the discharge plan) will appropriately reflect the ASAM Patient Placement Criteria. Consents for treatment, including medication should be included. Consultation reports are also kept in the file.

**SUPPORT SYSTEMS:** In Level III.5 Adolescent Programs, necessary support systems include:
• The supervising practitioner is available 24 hours a day, seven days a week in person or by phone. A psychologist or psychiatrist who serves as a supervising practitioner directs and supervises the individualized treatment plan of the youth in the program.
• Ability to arrange for appropriate medical procedures, including but not limited to indicated laboratory and toxicology testing, dental services and other diagnostic and treatment services.
• Ability to arrange appropriate medical and psychiatric treatment through referral or transfer to another level of care in emergency situations.
• Direct affiliation with other levels of care.

DIAGNOSTIC ADMISSION CRITERIA:
• The youth who is appropriately placed in this Level III.5 program meets the diagnostic criteria for a Substance Dependence Disorder or substance related disorder as defined in the current DSM IV, as well as the dimensional criteria for admission.
• Continued stay for Level III.5 is determined by reassessment of admission guidelines and response to treatment.
• The youth who is appropriately placed at this Level III.5 program meets specifications in two of Dimensions 1 through 6.
• The following six dimensions and criteria are abbreviated. Providers are responsible to refer to the ASAM PPC-2R ADOLESCENT PLACEMENT MANUAL for the complete criteria.

DIMENSION 1: ACUTE INTOXICATION AND/OR WITHDRAWAL POTENTIAL: The adolescent status in Dimension 1 is characterized by the following:
• The adolescent is at risk for experiencing acute and subacute intoxication or withdrawal with mild to moderate symptoms. He or she needs containment and increased treatment intensity to support engagement in treatment, ability to tolerate withdrawal and prevention of immediate continued use.
• Alternatively, the adolescent has a history of failure in treatment at the same or less intensive level of care. Problems with intoxication or withdrawal are manageable at this level of care.
• Alternatively, the adolescents with a history of failure in treatment at the same or less intensive level of care.

DIMENSION 2: BIOMEDICAL CONDITIONS AND COMPLICATIONS: The adolescent's status in Dimension 2 is characterized by one of the following:
• Biomedical conditions distract from recovery efforts and require residential supervision that is unavailable at a less intensive level of care, to ensure adequate treatment or the youth may require medium intensity residential treatment to provide support to overcome the distraction. Adequate nursing or medical monitoring can be provided.
• Continued substance use would place the adolescent at risk of serious damage to his or her physical health because of a biomedical condition or an imminent dangerous pattern of high risk use. Adequate nursing or medical monitoring for biomedical conditions can be provided.

DIMENSION 3: EMOTIONAL, BEHAVIORAL OR COGNITIVE CONDITIONS AND COMPLICATIONS: The adolescent's status in Dimension 3 is characterized by one of the following requiring 24-hour supervision and medium intensity therapeutic milieu:
• Dangerousness/Lethality: The adolescent is at moderate but stable risk of imminent harm to self or others and needs medium-intensity 24-hour monitoring and/or treatment for protection and safety.
• Interference with Addiction Recovery Efforts: The adolescent's recovery efforts are negatively affected by his or her emotional, behavioral or cognitive problems in significant and distracting ways. He or she requires 24-hour structured therapy and/or a programmatic milieu to promote, sustain, and focus on recovery tasks because of active symptoms.
• Social Functioning: The adolescent has significant impairments and moderate to severe symptoms such as poor impulse control. These seriously impair his or her ability to function in family, social, school or work settings and cannot be managed in a less intensive level of care.

• Ability for Self-Care: The adolescent has moderate impairment in his or her ability to manage the activities of daily living and thus requires 24-hour supervision and staff assistance, which can be provided by the program. The adolescent's impairments may involve a need for intensive modeling and reinforcement of personal grooming and hygiene and a pattern of continuing indiscriminate or unprotected sexual contact in an adolescent with a history of sexually transmitted diseases and self-neglect in the context of advanced alcohol or drug dependence, a need for intensive teaching of personal safety techniques in an adolescent who has suffered physical or sexual assault and the like.

• Course of Illness: The adolescent's history and present situation suggests that an emotional, behavioral or cognitive condition would become unstable without 24-hour supervision and a medium intensity structured programmatic milieu.

DIMENSION 4: READINESS TO CHANGE: The adolescent's status in Dimension 4 is characterized by one of the following:

• The adolescent requires 24-hour supervision and structured programmatic milieu to promote progress through the stages of change as evidenced by a lack of previous treatment engagement and/or extensive functional impairment.

• The adolescent has not related his or her problems to substance use or has not accepted the need to change and thus is in need of intensive motivating strategies, activities and processes available only in a setting with 24-hour supervision and a medium intensity milieu.

• The adolescent does not believe there is any problem in daily substance use, despite serious consequences to his or her life.

DIMENSION 5: RELAPSE, CONTINUED USE OR CONTINUED PROBLEM POTENTIAL: The adolescent’s status in Dimension 5 is characterized by one of the following:

• The lack of monitoring or supervision between treatment encounters at a less intensive level of care has been a major barrier to abstinence and achievement of recovery goals. The adolescent's continued substance use poses a high risk of serious impairment in the absence of 24-hour monitoring and structured support.

• The adolescent requires residential containment, treatment and structured programmatic milieu to further develop recovery skills that are not yet sufficient to overcome environmental triggers such as peer substance use or family stressors or internal triggers such as cravings. The adolescent's continued use poses a high risk of serious impairment in the absence of 24-hour monitoring and structured support.

• The adolescent's history of chronic substance use, repeated relapse and/or resistance to treatment predicts continued use or relapse without residential treatment and a structured programmatic milieu. For the adolescent at Level III.5 the setting is required to promote and prepare the youth for treatment response and relapse prevention at a less intensive level of care.

• The adolescent's likelihood of relapse and/or continued use poses a high risk of serious impairment in the absence of 24 hour monitoring and structured support. Such an adolescent may be at high risk of relapse/continued use because of ongoing exposure to substances in the context of trafficking, involvement with a gang or other delinquent or drug involved peers.

DIMENSION 6: RECOVERY ENVIRONMENT: The adolescent’s status in Dimension 6 is characterized by one of the following:

• The adolescent has been living in an environment in which there is a high risk of neglect or initiation or repetition of physical, sexual or severe emotional abuse, such that the adolescent is assessed as being unable to achieve or maintain recovery without residential treatment or
• The adolescent has family or other household member who has an active substance use disorder, or substance use is endemic in his or her home environment or broader social network so that the recovery goals are assessed as unachievable without residential treatment or
• The adolescent’s home environment or social network is too chaotic or ineffective to support or sustain treatment goals so that recovery is assessed as unachievable without residential treatment.
• Logistical impediments such as distance from the treatment facility, mobility limitations lack of transportation, preclude participation in treatment at a less intensive level of care.

Discharge/Transfer Criteria
It is appropriate to transfer or discharge the adolescent from the present level of care if he or she meets the following criteria:

1. The adolescent has achieved the goals articulated in his or her individualized treatment plan thus resolving the problem(s) that justified admission to the present level of care and has a comprehensive relapse plan in place that meets the individual needs of the adolescent.
   OR
2. The adolescent has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan. Treatment at another level of care or type of service is therefore indicated.
   OR
3. The adolescent has demonstrated a lack of capacity to resolve his or her problem(s). Treatment at another level of care or type of service is therefore indicated.
   OR
4. The adolescent has experienced an intensification of his or her problem(s), or has developed a new problem(s), and can be treated effectively only at a more intensive level of care.

To document and communicate the adolescent’s readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the existing or new problem(s), the adolescent should be discharged or transferred, as appropriate.

(8-1-08)
INPATIENT SUBSTANCE ABUSE TREATMENT (ASAM LEVEL III.7 MEDICALLY-MONITORED HIGH-INTENSIVE INPATIENT TREATMENT)

For Nebraska Medicaid Enrolled Providers of Acute Substance Treatment services, this subchapter applies to enrolled inpatient hospital facilities provided in an acute wing of an acute care hospital or a freestanding psychiatric hospital providing services for clients age 20 and younger. Hospital providers will adhere to the regulations of the Nebraska Medical Assistance Program (NMAP), Chapter 32 (471 NAC 32-008 Inpatient Mental Health and Substance Abuse Services) and the Medicaid Managed Care Handbook Supplement, Appendix B description for inpatient mental health and substance abuse treatment programs.

- The following is based on the Adolescent Criteria of the Patient Placement Criteria for the Treatment of Substance Related Disorders of the American Society of Addiction Medicine, Second Edition Revised (ASAM PPC-2R or current version) pages 235-269. Providers are responsible to refer to the ASAM PPC-2R Adolescent Placement Manual for complete criteria.

SERVICES: Adolescent Level III.7 medically managed intensive inpatient treatment is an organized service delivered in a psychiatric wing of an acute care hospital or a freestanding psychiatric facility with a program for the adolescent population. This level of care is appropriate for adolescents whose acute biomedical, emotional, behavioral and cognitive problems are so severe that they require primary medical and nursing care. Level III.7 program services are delivered by an interdisciplinary staff of mental health and addiction-trained psychiatrists and other appropriately credentialed treatment professionals. Such a program encompases a planned regimen of 24-hour medically-directed evaluation and treatment services, provided under a defined set of policies, procedures and clinical protocols.

Treatment is provided 24 hours per day. The full resources of psychiatric hospital services and general acute hospital care are available. Although treatment is specific for substance dependence disorders and mental health disorders, the skills of the interdisciplinary team and the availability of support services allow the cojoint treatment of any other co-occurring biomedical conditions and mental health disorders that need to be addressed.

DETOXIFICATION SERVICES: Providers are referred to Level IV Acute Inpatient Hospital Detoxification Services (med-surg) for medically managed intensive inpatient detoxification services.

HOURS: Level III.7 programs operate 24 hours per day and provide primarily medical and nursing care and treatment for psychiatric and substance abuse disorders. Service duration varies with severity and with youth’s response to treatment.

STAFFING: Level III.7 adolescent programs are staffed by an interdisciplinary team of appropriately licensed and credentialed clinical staff (including appropriately trained physicians, nurses, counselors, psychologists and social workers under the direction of a psychiatrist) who assess and treat adolescents with substance-related disorders or addicted adolescents with concomitant acute biomedical, emotional or behavioral disorders. Staff is knowledgeable about biopsychosocial dimensions of adolescent addiction and the biomedical and emotional, behavioral and cognitive disorders. A team of appropriately trained and credentialed professionals provide daily medical management 24 hours a day, primary nursing care and observation 24 hours a day, and professional counseling services daily. Facility approved addiction counselors or licensed, certified or registered addiction clinicians administer planned interventions according to the assessed needs of the adolescent.

THERAPIES: Therapies offered by Level III.7 adolescent programs include:
• A highly individualized program of treatment for mental health and substance dependence disorders and any concurrent biomedical, emotional, behavioral or cognitive problems delivered by an interdisciplinary treatment team.

• Cognitive, behavioral therapy, medication and other therapies provided on an individual or group basis depending on the adolescent's needs. For the adolescent who has a severe biomedical disorder, biomedical interventions are available to supplement addiction treatment. For the adolescent who has severe psychiatric problems, psychiatric interventions complement addiction treatment.

• Health education services.

• Planned clinical interventions that are designed to enhance the adolescent's acceptance of his or her substance dependence or mental health problem.

• Services involving the adolescent's family, guardian or significant others.

ASSESSMENT/TREATMENT PLAN:
In Level III.7 adolescent programs, elements of the assessment and treatment plan include:

• A comprehensive nursing assessment conducted at the time of admission.

• Psychiatrist approval of the admission by completion of the initial diagnostic assessment within 24 hours (or earlier if the acuity of the condition warrants).

• A comprehensive history and physical examination performed by a physician usually at the time of admission or shortly thereafter.

• A comprehensive biopsychosocial assessment initiated at the time of admission.

• An educational assessment performed to assist in the design of an appropriate educational program.

• Referral arrangements for continued treatment at another level of care as needed.

• An individualized treatment plan which includes problem formulization and articulation of treatment goals and measurable treatment objectives.

DOCUMENTATION: Documentation standards at Level III.7 adolescent program include:

• A comprehensive diagnostic assessment by a psychiatrist;

• Nursing assessment by a registered nurse;

• Biopsychosocial assessment;

• Physician orders and progress notes;

• Treatment plan reviews and treatment plan revisions by the multidisciplinary treatment team;

• Therapist notes and daily therapy progress notes by the interdisciplinary staff.

The documents must be kept in the youth's clinical record and must clearly reflect implementation of a treatment plan and the adolescent's response to treatment. The chart must also reflect aggressive discharge planning as the youth progresses to the next level of care.

SUPPORT SYSTEMS: Necessary support systems include:

• Psychiatrist monitoring and nursing care must be available onsite as needed, based on clinical need. A psychiatrist is available to assess the youth at admission and thereafter as medically necessary. A registered nurse conducts an alcohol or other drug-focused nursing assessment, provides nursing interventions and supervises the dispensation of medication.

• Additional medical specialty consultation, psychological, laboratory, and toxicology services are available through consultation or referral.

• Direct affiliation with other levels of care.

• Psychiatric services are available through consultation or referral for the next level of care for clients in preparation for discharge. Such services are available within 8 hours by telephone or 24 hours in person.

DIAGNOSTIC ADMISSION CRITERIA:
Youth who is appropriately placed in a Level III.7 program meet the diagnostic criteria for a Substance Dependence Disorder, as defined in the current DSM (Diagnostic and Statistical Manual of Mental Disorders) IV, as well as the dimensional criteria for admission.

Continued stay is determined by reassessment of admission guidelines and response to treatment.

The youth who is appropriately admitted to a Level III.7 program meets specifications in two of the six dimensions; at least one of the Dimensions 1-6 with at least one of which is in dimension 1, 2 and 3.

The following six dimensions and criteria are abbreviated. Providers are responsible to refer to the ASAM PPC-2R ADOLESCENT PLACEMENT MANUAL for the complete criteria.

DIMENSION 1: ACUTE INTOXICATION AND/OR WITHDRAWAL POTENTIAL: The adolescent status in Dimension 1 is characterized by the following:

- The youth is experiencing or at risk of acute or subacute intoxication or withdrawal with moderate to severe signs and symptoms.
- He or she needs 24 hour treatment services including the availability of active medical and surgical monitoring to manage withdrawal, support engagement in treatment and prevention of immediate continued use.
- Alternatively the youth has a history of failure in treatment at the same or less intensive level of care.
- Problems with intoxication or withdrawal are manageable at this level of care. Specific examples:
  - Alcohol. Moderate withdrawal with significant symptoms that require access to nursing and medical monitoring. The patient may have a history of daily drinking or drinking to self-medicate withdrawal, or regular morning drinking. He or she may require sedative-hypnotic substitution therapy but typically this can be managed with a standing taper without the need of extensive titration.
  - Sedative hypnotics. Moderate withdrawal with significant symptoms that require access to nursing and medical monitoring. The adolescent may be cross-dependent on other substances and may require detoxification with tapering substitute agonist therapy and/or pharmacological management of symptoms.
  - Opiates. Moderate to severe withdrawal usually in the context of daily opiate use. The patient requires access to nursing and medical monitoring; may require use of prescription medications or agonist substitution therapy and may need monitoring for induction of antagonist therapy.
  - Stimulants. Severe withdrawal involving sustained affective or behavioral disturbances or mild psychotic symptoms which requires access to nursing and medical monitoring. Severe craving states or affective instability typical of withdrawal may require high intensity, 24 hour treatment to support engagement.
  - Inhalants. Severe subacute intoxication of sufficient intensity that the patient requires access to nursing and medical monitoring.
  - Marijuana. Severe sustained intoxication, involving mild psychosis, cogitative disorganization, agitation and the like which requires access to nursing or medical monitoring.
  - Hallucinogens. Severe persistent intoxication involving mild delirium, mild psychosis, agitation, moderate to severe affective instability, cogitative disorganization which requires access to nursing and medical monitoring.

DIMENSION 2: BIOMEDICAL CONDITIONS AND COMPLICATIONS: The adolescent status in Dimension 2 is characterized by one of the following:

- Biomedical complication of addiction or co-occurring biomedical condition that requires active nursing or medical monitoring, which can be provided directly by the program or through an arrangement with another provider and which does not require the resources of an acute care hospital, or
Continued alcohol or drug use places the adolescent at imminent risk of serious damage to physical health because of a biomedical condition (such as brittle diabetes, pregnancy or HIV) which requires active nursing and medical monitoring.

DIMENSION 3: EMOTIONAL, BEHAVIORAL OR COGNITIVE CONDITIONS AND COMPLICATIONS: The adolescent status in Dimension 3 is characterized by one of the following requiring 24 hour supervision and high intensity therapeutic milieu with access to nursing and medical monitoring and treatment.

- Dangerousness/lethality. The adolescent is at moderate and possibly unpredictable risk of imminent harm to self or others and needs 24 hour monitoring and/or treatment in a high intensity programmatic milieu and/or enforced containment for safety.
- Interference with addiction recovery efforts. The adolescent’s recovery efforts are negatively affected by his or her emotional, behavioral or cognitive problems in significant and distracting ways. He or she requires 24 hour structured therapy and/or high intensity programmatic milieu to stabilize unstable emotional or behavioral problems as through ongoing medical or nursing evaluation, behavior modification, titration of medication and the like.
- Social functioning. The adolescent has significant impairments with severe symptoms such as poor impulse control, disorganization and the like, which would seriously impair his or her ability to function in family, social, school or work settings and which cannot be managed at a less intensive level of care. These might involve a recent history of aggressive or severely disruptive behavior, severe inability to manage peer conflict or recurrent or persistent pattern of runaway behavior requiring enforced confinement and the like.
- Ability for self care. The adolescent has a significant lack of personal resources and moderate to severe impairment in the ability to manage activities of daily living, he or she thus needs 24 hour supervision and sufficient staff assistance, including access to nursing or medical services. The adolescent’s impairments may involve progressive and severe dilapidation and self neglect in the context of advanced substance dependence, the need for observation after eating to prevent self induced vomiting and the need for intensive reinforcement of medication compliance, the need for intensive modeling of adequate self care during pregnancy, the need for intensive training for self care in a cognitively impaired patient and the like.
- Course of illness. The adolescent’s history and present situation suggest that the emotional, behavioral or cognitive condition would become unstable without 24 hour supervision and a high intensity structured programmatic milieu with access to nursing or medical monitoring or treatment. These may be required to treat an adolescent who for example, requires containment or enforced abstinence for reinstatement or titration of pharmacological treatment regimen or the adolescent who’s substance use has been associated with a dangerous pattern of aggressive/violent behavior and who needs monitoring to access safety and likelihood of outpatient treatment success before returning to the community following release from a juvenile justice setting or an adolescent who requires intensive monitoring or treatment because ongoing substance use prevents adequate or safe treatment or diagnostic clarification for an emotional, behavioral or cognitive condition that may or may not be substance induced; or an adolescent who’s history suggests rapid escalation of dangerousness/lethality when using alcohol or drugs and who is in relapse or at imminent risk of relapse.

DIMENSION 4: READINESS TO CHANGE: The adolescent status in Dimension 4 is characterized by one of the following:

- The adolescent has not related his or her problems to substance use or has not accepted the need to change. Therefore, treatment is likely to succeed only at Level III.7. For example, the adolescent does not recognize that substance use causes his or her disorganization and thus cannot adequately manage his or her diabetes or other chronic illness or the adolescent does not acknowledge that he or she is impaired by overuse of opioid and analgesics and therefore cannot adequately manage his or her sickle cell
disease or the adolescent does not recognize the ways in which substance use exacerbates his or her aggressiveness and cannot avoid dangerous altercations and the like; or

• The adolescent has not demonstrated sufficient readiness to change and thus is in need of intensive motivating strategies, activities and processes available only in a 24 hour high intensity structured milieu or medically monitored setting to promote or sustain treatment engagement or readiness to change. For example, the adolescent may need the availability of intensive behavior modification with access to timeout or a quiet room or therapeutic holds to manage his or her disruptive response to treatment or intensive motivational enhancement therapies requiring this level of staffing monitoring and 24 hour structure or intensive case management to link and prepare relevant participants such as family, probation officer, or school for implementation of a plan to sustain treatment engagement at a less intensive level of care.

DIMENSION 5: RELAPSE, CONTINUED USE OR CONTINUED PROBLEM POTENTIAL: The adolescent status in Dimension 5 is characterized by one of the following requiring high intensity 24 hour supervision and structured programmatic milieu with access to nursing and medical monitoring and treatment to prevent relapse or continued use attenuate:

• The adolescent is unable to interrupt high frequency/high severity pattern of use with imminent severe risk of dangerous consequences; that adolescent may have severe and persistent problems with impulse control that requires stabilization through high intensity interventions or he or she has issues with intoxication or withdrawal that require stabilization in a medically monitored setting, or there is imminent risk of danger to self or others with relapse or continued use, or there is a likelihood of self medication of recurrent symptoms of a mood disorder which require stabilization in a medically monitored setting. Treatment at a less intensive level of care has been attempted or given serious consideration; or

• The modality of treatment requires Level III.7 level of care. Level III.7 care is required to safely and effectively titrate antagonist therapy or agonist substitution therapy, or aversion therapy, or level III.7 care is required for monitoring, case management, and documentation needed to arrange a less intensive level of care or other needed treatment resources.

DIMENSION 6: RECOVERY ENVIRONMENT: The adolescent status is characterized in Dimension 6 by one of the following:

• The adolescent has been living in an environment in which supports that might otherwise have enabled treatment at a less intensive level of care are unavailable. The family may undermine the adolescent’s treatment or is unable to sustain treatment attendance at a less intensive level of care or the family members have active substance use disorders and/or facilitate access to alcohol or other drugs or the home environment is dangerously chaotic or abusive or the family is unable to adequately supervise medications or the family is unable to adequately implement a needed behavior management plan. Level III.7 is thus needed to affect change in the home environment so as to establish a successful transition to a less intensive level of care; or

• Logistical impediments preclude participation in treatment at a less intensive level of care and Level III.7 care thus is needed to effect necessary to establish a successful transition to a less intensive level of care.

Discharge/Transfer Criteria

It is appropriate to transfer or discharge the adolescent from the present level of care if he or she meets the following criteria:

1. The adolescent has achieved the goals articulated in his or her individualized treatment plan thus resolving the problem(s) that justified admission to the present level of care and has a comprehensive relapse plan in place that meets the individual needs of the adolescent.
OR
2. The adolescent has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan. Treatment at another level of care or type of service is therefore indicated.

OR
3. The adolescent has demonstrated a lack of capacity to resolve his or her problem(s). Treatment at another level of care or type of service is therefore indicated.

OR
4. The adolescent has experienced an intensification of his or her problem(s), or has developed a new problem(s), and can be treated effectively only at a more intensive level of care.

To document and communicate the adolescent’s readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the existing or new problem(s), the adolescent should be discharged or transferred, as appropriate.

(8-1-08)
LEVEL IV: MEDICALLY-MANAGED INTENSIVE INPATIENT DETOXIFICATION SERVICE

DEFINITION

For Nebraska Medicaid Enrolled Providers of acute substance treatment services, this subchapter applies to detoxification services provided by Medicaid enrolled providers of acute inpatient hospital services (med-surg). Providers will adhere to the regulations of the Nebraska Medical Assistance Program (NMAP), Chapter 10 (471 NAC 10-000), particularly 471 NAC 10-005.12 Alcohol and Chemical Detoxification for alcohol and chemical detoxification services.

SERVICES: Adolescent Level IV medically managed inpatient detoxification, stabilization, and treatment is an organized service delivered in an acute care inpatient hospital setting. It is appropriate for adolescents whose acute biomedical, emotional, behavioral and cognitive problems are so severe that they require primary medical and nursing care. Level IV program services are delivered by an interdisciplinary staff of addiction-trained and experienced physicians, nurses, and other appropriately credentialed treatment professionals. Such a program emphasizes a planned regime of 24 hour medically-directed evaluations and treatment services provided under a defined set of policies, procedures and clinical protocols.

LENGTH OF STAY: Duration of treatment varies with the severity of the adolescent's illness and his or her response to treatment. However, a period of 2-3 days is the average length of stay. Occasionally, if medical need indicates, the patient may be treated up to 5 days when and if the condition dictates.

NOTE: Inpatient, medically-managed intensive inpatient detoxification services are available to Medicaid Managed Care clients of all ages. However, this service is Not authorized or managed through the ASO. Services must be medically necessary and are reimbursed as described in 471 NAC 10-010.

(8-1-08)