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B-1 Introduction

Philosophy and Core Values
Magellan Behavioral Health of Nebraska (hereafter Magellan) is committed to providing treatment at the least-restrictive level of care necessary to assure safe and effective treatment and meet the mental health and substance needs of eligible individuals and their families. Magellan believes in providing the right treatment, in the right amount, at the right location, for the right length of time. We see the continuum of care as a fluid treatment pathway, where clients may enter treatment at any level and be moved to more or less intensive settings or levels of care as their changing clinical needs dictate. In order to meet Magellan expectations, contracted mental health and substance use disorder providers render care with the following characteristics:

Active and Effective Treatment Plans
Active treatment plans are based on a thorough evaluation of the client’s current symptoms, problems, restorative needs and strengths. The treatment plan addresses the specific event or trigger which caused the member to present for treatment and has specific measurable goals and is time limited. Addressing why-now events, improving functioning and reducing symptoms, provides evidence of active treatment planning. Active treatment does not include maintenance and supportive approaches to therapy. Active treatment also addresses symptoms of temporary regression due to the normal course of therapy.

Effective treatment programs utilize clinical outcome measures to inform both the individual treatment plan and the program’s system of care. To support treatment effectiveness, Magellan offers secure web-based outcomes measurement programs for our providers and members; The Child and Adolescent Needs and Strengths (CANS) assessment and the Consumer Health Inventory (CHI) are available. The CANS assessment is required for residential treatment providers and is available for all providers who are interested in improving outcomes. Training and certification are available online to all Magellan providers.

Family Centered Practice
Treatment includes family members in all aspects of treatment planning and service delivery. Family members may be biological or others as identified by the client. The inclusion of the family in assessment, treatment planning and ongoing intervention is a family centered best practice and plays a key role in the overall success of treatment approaches.

Resiliency and Recovery Informed
Cultivating a strengths-based, client and family centered system of care that is recovery oriented and allows individuals and families to achieve their goals is one of
Magellan’s highest priorities. The principles of resiliency and recovery are as follows:

1. Demonstrate appreciation
2. Respect culture and language, and communicate effectively
3. Discover and support the strengths, skills and attributes of others
4. Think holistically about all areas of people’s lives
5. Focus on self-determined readiness
6. Offer meaningful choices
7. Optimize peer, family and natural supports
8. Promote self-confidence in others
9. Measure, monitor and improve
10. Celebrate and share success
11. Create opportunities for meaningful consumer and family involvement
12. Model these principles in actions, language and decisions.

All people have qualities that enable them to rebound from adversity, trauma, tragedy or other stresses and to go on with life with a sense of mastery, competency and hope. All people living with behavioral health conditions have the capacity to learn, grow and change, and can achieve a life filled with meaning and purpose. Magellan supports a philosophy of wellness that focuses on personal strengths, building hope and offering choices. Our focus on resiliency and recovery means that we help individuals and families achieve:

- A sense of belonging
- A safe place to live
- Days filled with purpose
- Skills to achieve wellness
- A strong voice in their own lives
- Hope and confidence in themselves and their future.

**Trauma Informed Practices**

Studies indicate that traumatic life events predispose individuals to increased incidences of both physical and mental health problems. Trauma informed care is based on assessment and treatment of individuals adversely affected by traumatic life events as part of and integrated with the overall treatment approach. In addition, trauma informed care creates mental health treatment environments and practices that reduce incidents that may re-traumatize individuals during the course of mental health treatment. Magellan works closely and consistently with all providers to improve their assessment and treatment of traumatized members.
reduce further trauma through implementation of models that are strength-based such as the sanctuary model.

**Culturally Competent Practices**
Magellan supports cultural sensitivity and competency in our provider practice community. This includes awareness, acceptance and respect for differences and continuing self-assessment regarding culture. Treatment services should be delivered in the member's preferred language.

Cultural competence includes careful attention to the dynamics of differences among clients and how they affect interactions, assumptions and the delivery of services. Providers also demonstrate cultural competence through continuous expansion of cultural knowledge and resources through training, readings, etc., and by providing a variety of adaptations to treatment models in order to meet the needs of different cultural populations.

**B-2 Benefit Plan Description**

**Covered Services: Children and Adolescents**
When medically necessary, the following services, when delivered by a contracted clinician practicing within their scope of practice and performed in accordance with Magellan’s authorization requirements are covered:

**Assessments**
- Evaluation and Management services
- Psychiatric Diagnostic Evaluation
- Comprehensive Child and Adolescent Assessment
- Substance Use Disorder Assessment
- Sex Offense Risk Assessment
- Psychological Testing and Evaluation

**Mental Health and Substance Use Disorder Treatments**
- Medication Management
- Crisis Therapy
- Client Assistance Program (CAP)
- Case Conferences
- Psychotherapy (Individual, Family and Group)
- Community Treatment Aide
- Intensive Outpatient
- Day Treatment
- Psychiatric Residential Treatment Facility
- Therapeutic Group Home
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- Professional Resource Family Care
- Crisis Observation (23:59)
- Partial Hospitalization
- Inpatient

Non-covered Services: Children and Adolescents

The following are services that are not covered regardless of the member's diagnosis:

- Biofeedback services
- Educational services
- Eye movement desensitization and reprocessing
- Vagus nerve stimulation
- Holding therapy or corrective attachment therapy
- Hippotherapy, equine movement therapy or horseback riding
- Play therapy
- Art therapy
- Music Therapy
- Psychotherapy for pain management
- Supportive and maintenance therapy
- Transmagnetic Stimulation (TMS)
- Couple / Marital

Outcome Measures

Effective treatment programs utilize clinical outcome measures to inform both the individual treatment plan and the program’s system of care. To support treatment effectiveness, Magellan offers secure web-based outcomes measurement programs for our providers and members. The Child and Adolescent Needs and Strengths (CANS) assessment and the Consumer Health Inventory (CHI) are available. The CANS assessment is required for residential treatment providers and is available for all providers who are interested in improving outcomes. CANS Training and certification is available online to all Magellan providers.

CANS
Residential treatment providers of Therapeutic Group Home and Psychiatric Residential Treatment Facility are required to complete a CANS assessment for each youth within 10 days of admission and to incorporate CANS assessment data into
the treatment plan. Subsequent CANS are administered every 90 days of continuous residential treatment and at discharge. Data from each administration of the CANS are entered into the online Magellan CANS outcomes management system. If less than 30 days have passed since the last CANS was administered a new CANS is not completed. However, the previous CANS is to be re-entered into the Magellan CANS system as the designated discharge CANS. Each provider is encouraged to develop ways to use CANS outcome data in treatment and to share their successes with other through collaborative experiences such as the Magellan Super User calls. The following are examples of ways the CANS may be utilized to improve outcomes:

- To answer the question of whether a client is responding to the treatment being offered
- To inform the individual treatment plan and provide direction for further treatment
- To build consensus in the interdisciplinary team regarding treatment needs and client strengths
- To reinforce and build family involvement in all levels of treatment including residential treatment
- To treatment as a quality improvement tool to monitor program effectiveness and establish the need for further action
- To inform the program’s system of care by comparing different groups within the same treatment program to see which groups have better outcomes.

**Consumer Health Inventory**

The Consumer Health Inventory (available in adult and child versions) is available for all Magellan providers by going to our web-based outcomes measurement system—known as Outcomes360 at MagellanHealth.com/provider or MagellanofNebraska.com. These tools enable members (consumers) and/or their caretakers to assess and track progress related to their mental and physical health.

Magellan worked closely with Quality Metric, Incorporated, the industry leader in health status measurement, to design these brief outcomes measurement tools:

- **Consumer Health Inventory (CHI)** -- Tool completed by consumers age 14 and older covered by government (e.g., federal and state) sponsored programs

- **Consumer Health Inventory – Child Version (CHI-C)** -- Tool completed by caregivers of children less than 18 years of age

You can use the assessment process and reports to enhance treatment planning for each member in your care. Note that children’s caretakers complete the CHI-C assessment.
The Outcomes360 tools are key components of Magellan’s behavioral health outpatient programs through which we focus on improving members’ health and wellness, quality of life, and physical and emotional health.

For questions about Outcomes360, call our national Provider Services Line at 1-800-788-4005, or send us a secure email message and we will respond to your request promptly.

**Medical Leave Day Policy and Requirements**

All children and youth authorized for treatment in Psychiatric Residential Treatment Facility (PRTF), Therapeutic Group Home (ThGH), and Professional Resource Family Care (PRFC) levels of care are eligible for a maximum of 15 medical leave days per episode of care. The parents/guardians are expected to be notified immediately of a youth’s admission to a hospital or acute care (psychiatric or medical) or 24-hour rehabilitation program for medical treatment. The program will continue to provide contact and support for the youth and their family during medical leave days. The program and the parent/guardian will work closely with the hospital or medical rehabilitation treatment team to assist with approaches to care and discharge planning. The program will continue to bill for authorized days up to 15 days per episode of care as long as the program is holding a bed for the youth’s return. The program will incorporate all on-going follow up treatment recommendations into the youth’s treatment plan whether medical or behavioral.

**Therapeutic Leave Day (TLD) Policy and Requirements**

All children and youth authorized for treatment in Psychiatric Residential Treatment Facility, Therapeutic Group Home and Professional Resource Family Care levels of care are eligible for 14 therapeutic overnight visits home. The parents/guardians are expected to provide close supervision and care for the youth as per the program’s Supervising Practitioner’s direction. Therapeutic Leave Days are regarded as an essential component of the overall treatment and discharge plan. As an intervention, it is described with goals in the youth’s treatment plan to facilitate on-going discharge efforts and to promote the generalization of therapeutic gains in the community. Each TLD will have a corresponding progress note in the chart, which will include specific feedback from the youth’s parent/guardian regarding the youth’s progress and recommendations to the treatment team regarding goal adjustments for subsequent Therapeutic Leave Days. The treating provider is responsible for arranging transportation in accordance with Medicaid guidelines.
B-3 Standards Common to all Levels of Care

Magellan has specific standards and requirements for each level of care and program offered within our network. The information below outlines standards that are applicable to all levels of care. These standards will be reviewed regularly and all modifications will be posted on the Magellan website.

- The HEALTH CHECK (EPSDT) Screen is required for members 18 and younger either prior to the initiation of mental or substance use disorder health services or within eight weeks after the initiation of mental health or substance use disorder services.
- Services must be family and client centered, culturally competent, trauma informed, and developmentally appropriate.
- The provider must be actively enrolled with Nebraska Medicaid for the specific level of service and be appropriately credentialed and contracted with Magellan.
- Services must have been determined to be medically necessary (see Appendix C).
- The member must have an active DSM (current version) diagnosis (except for Client Assistance Program (CAP) services).
- Providers of substance use disorder treatment services will adhere to all criteria outlined in the American Society of Addiction Medicine, The ASAM Criteria (current version).
- Services must be prior-authorized by Magellan when required.

Clinical oversight of non-independent practitioners and treatment programs must be provided by a Supervising Practitioner (for services and professionals who require this supervision) who possesses the appropriate licensure specified for the level of care and
- Is credentialed as a Magellan network provider, when necessary
- Is an enrolled Nebraska Medicaid provider
- Is contracted by Magellan
- Meets the requirements outlined for each level of care
- Conducts an Initial Diagnostic Interview and subsequent assessments to confirm the member’s diagnosis, develop and update active treatment recommendations for medically necessary services, evaluate member progress and assess member’s ongoing treatment needs
- Meets with the family and the provider or treatment team regularly to review the member’s progress and discuss needed modifications to the treatment plan
- Directly participates in the development and supervises the comprehensive treatment plan in the frequency prescribed by the level of care (the
treatment plan contained in the initial assessment serves until the comprehensive treatment plan is developed).

- Directs patient care by reviewing and approving client specific treatment plans and progress notes within the timelines specified for each level of care
- Monitors and supervises the treatment services provided, assuring that the treatment provided meets standards of care
- Assists in the development of the discharge plan each time the treatment plan is updated
- Periodically evaluates the therapeutic program and determines if treatment goals are being met and if changes in direction or emphasis are needed
- Provides supervision to treating therapist(s) every 30 days or more often as necessary or as identified in the level of care description. Direct face-to-face contact is preferred; however, communication may occur via telephone or Telehealth. Supervisory content shall include:
  - A review of the treatment recommendations,
  - An update on the individual's current status, progress achieved, and barriers to progress. This update shall also include critical incidents, especially those involving individual safety or danger to self or others,
  - A review and signature of approval on the treatment plan and progress notes, and
  - Determination of modifications to the treatment plan to expedite recovery and resiliency, and remove barriers to progress, with a special emphasis on patient or other person's safety. Review of the discharge plan and recommendation for changes.
  - Documentation of each supervisory session shall be in the individual's treatment record.

Some programs also require a Program/Clinical Director. The Program/Clinical Director oversees, implements and coordinates all treatment services and activities provided within the program under the direction of the Supervising Practitioner (when applicable). As such, the Program/Clinical Director:

- Meets the requirements outlined for each level of care
- Oversees, implements and coordinates all treatment services and activities provided within the program.
- Continually incorporates new clinical information and best practices into the program to assure program effectiveness and viability.
- Oversees the process to identify, respond to and report crises in a timely basis following their occurrence.
- Is responsible, in conjunction with the supervising practitioner, for the program’s clinical management.
- Assures quality, organization, confidentiality and management of clinical records and other program documentation.
- Oversees the gathering of outcome data and determine the effectiveness of the program for the individuals served.
• Supervises all procedures and training regarding behavior management in the program, particularly regarding de-escalation techniques and the use of timeout.
• Supervises Program Staff, in conjunction with the Supervising Practitioner.

All services (with the exception of CAP or Crisis therapy services) are provided under the direction of a comprehensive treatment plan. The treatment plan will:
• Be developed by the treatment team, including any Supervising Practitioner, the member, and the member’s family and/or guardian for minors.
• Is based upon the assessment/evaluation including treatment needs and individual/family strengths. This assessment results in a current and active DSM (current version) diagnosis along with treatment/rehabilitation goals.
• Include recommendations to treat the specific event that necessitates treatment.
• Document involvement of the member and his/her family/guardian in its development.
• Describe therapeutic interventions prescribed by the treatment team and establishes specific treatment goals and treatment interventions.
• Interventions must be outcome-focused based on the comprehensive assessment, treatment/rehabilitation goals, culture, expectations and needs as identified by the client.
• Include measurable goals and time frames for completion
• Is updated for changes in the individual’s condition, based on ongoing assessment of the individual’s progress and outcomes of treatment. If progress is not being made, the treatment plan must be adjusted to promote progress.
• Document ongoing discharge planning. Discharge planning starts at admission and must be included in the treatment plan and all treatment plan reviews.
• Be completed within the timeframe required by the specific level of care.

Documentation Standards: The program shall follow policy and procedures that meet accreditation, Medicaid and Magellan guidelines. Documentation shall be organized and legible, containing the date, time, and complete name and title of the facilitator of any treatment service provided to the individual. All progress notes shall contain the name, title and signature of the author, and when appropriate, the signature of the Supervising Practitioner. Clinical documentation must provide information that fully discloses the interventions and outcome of treatment services. Individual records must be maintained for a minimum of seven years, or longer to meet record retention standards. All individual records of service must be readily available in English. The provider shall make the clinical record available
upon Medicaid and/or Magellan’s request to review or receive a copy of the complete record. For specific details regarding Magellan standards, go to:

- www.MagellanofNebraska.com
- For Providers
- Treatment Record Review

**Length of Service:** Length of service (LOS) is individualized, based on Magellan/Medicaid medical necessity criteria and Medicaid eligibility. Outpatient Crisis and Client Assistance Program (CAP) services are limited to five sessions per year, per individual.

**Coordination of Care:** Services are appropriately coordinated:

- If multiple providers are rendering treatment services for the same individual or family, each provider must coordinate treatment services with the other. Documented coordination of services is required as part of the overall treatment plan and is not billable as a separate Medicaid service. If the member / guardian does not consent to these coordination of care activities, or if the provider believes coordination of care is contra indicated, supporting documentation is required.
- Providers must provide consultation and/or referral for general medical, psychiatric, psychological, and psychopharmacology needs.
- The therapist/licensed clinician must assist in identification and utilization of community resources and natural supports that must be identified in the discharge plan.
- The therapist/licensed clinician must coordinate care with the individual’s physician and any other mental health or substance use disorder treatment providers. If the member / guardian does not consent to these coordination of care activities, or if the provider believes coordination of care is contra indicated, supporting documentation is required.

**Restraint & Seclusion**
- Permitted only as per program accreditation and federal CFR regulations. Restraint and seclusion are not permitted in levels of care for which there are no applicable federal CFR regulations governing these interventions.

**General Requirements**
Programs or providers must complete a pre-service background check on all staff working with children/adolescents, to include:

- History of child abuse
- History of vulnerable adult abuse
- Motor vehicle record
- Criminal record
- Sex offender registry.
All background checks must be completed and documented annually in the employee personnel file.

The following information must be on file with Magellan:

- Credentialing application
- Comprehensive program description (except for outpatient)
- Required policies and procedures
- Copy of current state license/certification
- List of staff by position and credential (updated when changes occur)
- Proof of Nebraska Medicaid Certification
- Proof of professional liability
- Proof of general liability
- W-9 form.

The program/agency must have written policies/procedures as appropriate related to:

- Agency/program philosophy
- Individual record storage and clinical documentation
- Suicide assessment/prevention protocols
- Abuse and neglect reporting
- Access to emergency medical care
- Quality improvement
- Critical/adverse incident reporting
- Pre-service staff training
- Access to higher levels of care
- Assessment and treatment planning
- Utilization review
- Discharge planning
- Grievance procedures
- Individual’s rights and responsibilities
- Discovery of contraband including illicit drugs and weapons
- Seclusion and/or physical restraint (covering CFR requirements)
- Individual elopement (as applicable)
- Discipline philosophy and methods
- Infection control and risk management
- Emergency preparedness
- Administration and storage of medication (as applicable)
- Non-discrimination
- Coverage for Supervising Practitioner
- Drug Free Workplace
- Family involvement in treatment efforts
**Training:** All program staff must receive pre-service training that will minimally include:
- Family and client centered practice and trauma informed care.
- Recovery and resiliency training.
- Successful completion of the agency’s/program’s training and the related competency checks.
- De-escalation techniques and aggression management.
- Crisis intervention strategies.
- Behavior management planning and techniques.
- The role of medication in psychiatric treatment.
- Common psychotropic medications.
- Common child/adolescent psychiatric diagnoses and their treatment.
- Dealing with psychiatric emergencies.
- Physical restraint techniques (in compliance with CFR requirements), their indicators and contra-indicators, if used.
- CPR and first aid.
- Confidentiality and HIPAA privacy policy.

**B-4 Covered Services**

**Assessment**

**Initial Diagnostic Interview**

For services to be covered by Magellan, there must be a DSM (current version) diagnosis which results in functional impairments and interferes with or limits the member’s functioning within the family, job, school, or community. This assessment is used to identify the strengths, problems and needs, develop goals and objectives, and determine appropriate strategies and methods of intervention for the client. The assessment must occur prior to the initiation of treatment interventions and must include a baseline of the client’s current functioning and treatment needs. The assessment must include but is not limited to the following information:

- Reason member is seeking services or “why now”

- Comprehensive Mental Status Exam by the Independent practitioner or Supervising Practitioner that supports the treatment diagnosis, including the Supervising Practitioner recommendations for active treatment interventions.

- DSM (current version) Diagnosis
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- History & symptomology consistent with DSM (current version) criteria
- Psychiatric treatment history
- Co-occurring (co-morbid) substance induced disorder assessed
- Current and past suicide danger risk assessed
- Level of familial supports assessed and involved as indicated
- Consumer Identified areas for improvement
- Medical history
- Exploration of allergies and adverse reactions
- All current medications with dosages
- Discussion of discharge planning and linkage to next level
- Assessment of consumer strengths, skills, abilities, motivation etc.

An initial diagnostic interview is appropriately completed whenever a new episode of care begins. Additionally, if a new independently licensed practitioner or a new supervising practitioner assumes the member’s care, an initial diagnostic interview can be completed to confirm diagnosis and prescribe treatment interventions. If the member starts a new episode of care or is referred to a new level of care but the independently licensed practitioner or supervising practitioner remains the same, a new Initial Diagnostic Interview is not needed.

**Comprehensive Child and Adolescent Assessment (CCAA)**

**Purpose and Definition:**
Nebraska Revised Statute (NRS) 43-413(3) requires that all juveniles (i.e., youth age 18 and younger) be evaluated prior to commitment to the Office of Juvenile Services (OJS). NRS 43-403(3) defines evaluation as an assessment of the juvenile’s social, physical, psychological and educational development and needs, including a recommendation of an appropriate treatment plan. The intent of the CCAA is to provide a comprehensive assessment of the behavioral health and substance use disorder needs of youth age 18 and younger, performed by a coordinated team of professionals. The expectation is that the final set of treatment recommendations and diagnostic impressions is the consensus of the interdisciplinary team.

The CCAA is:
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- An enhanced assessment for a youth with behavioral symptoms and delinquent behaviors severe enough to call them to the attention of the juvenile court
- Used by the treating practitioners to determine a diagnosis and development of a comprehensive treatment plan with treatment goals and objectives along with appropriate strategies and methods of intervention for the youth
- Completed prior to the initiation of treatment and must document the youth's current functioning and treatment needs
- Not for educational purposes
- Completed when the youth has behavioral health symptoms or a history of behaviors that are so severe the youth cannot function safely in society because he or she presents a risk to self or others, or are so severe they interfere with age-appropriate and developmentally relevant activities of daily living
- Expected to provide an accurate diagnosis, treatment recommendations and appropriate strategies and methods of intervention
- The OJS evaluation, in its entirety, is utilized by the judge in making final recommendations for treatment and/or placement of the youth.

Policy:
The CCAA is authorized by Magellan and paid by Magellan. The CCAA must be court ordered. The CCAA shall be completed for all OJS evaluations, regardless of the youth's Medicaid status (non-Medicaid, Medicaid and Managed Care). If a youth has received a CCAA in the last 12 months, and the court orders a subsequent evaluation, the Magellan contracted provider shall complete an addendum to “update” the current CCAA.

Practitioner Requirements:
The CCAA is completed by licensed professionals operating within their scope of practice. CCAA providers are enrolled in Medicaid as a MH/SUD provider, credentialed and have a CCAA provider contract with Magellan. Contracted CCAA providers will demonstrate proficiency in conducting and documenting assessments in a standard manner that will assist in treatment planning for children and adolescents, and will maintain timely and quality assessments. Each contracted CCAA provider team will have a group of professionals including, at a minimum, a Licensed Mental Health Practitioner (LMHP)/Licensed Alcohol Drug Addiction Counselor (LADAC); Psychologist; Physician to complete the Wellness Check, if necessary; Licensed Clinician with documented expertise to conduct risk assessments (SO, eating disorder, etc.) and Psychiatrist. While the contracted provider team is comprised of many professionals, the CCAA will be coordinated and completed as one standardized report under one designated Supervising Practitioner.

Required Assessment Instruments:
The Comprehensive Adolescent Severity Inventory (CASI), administered by a certified user. In addition and not a requirement, Magellan recommends using the CANS administered by a certified CANS user.

**Components of the CCAA:**
The CCAA is comprised of two parts: I) the assessment to establish treatment/medical recommendations (i.e., clinical/medically based), and II) need/risk assessment (i.e., non-clinical part/OJS based).

The CCAA serves as the assessment to establish treatment/medical recommendations. The completed CCAA is forwarded to the HHSS Office of Juvenile Services/Protection and Safety worker, who are responsible for completing the second part of the OJS evaluation and forwarding both parts to the court of jurisdiction. The CCAA results in a standardized report that must be signed by the Supervising Practitioner. It is the responsibility of the Supervising Practitioner to coordinate all the assessment information, make a final recommendation for treatment and sequence the order of treatment if more than one recommendation is made. The standardized report may be used by treating professionals, probation officers, Protection and Safety Workers, Courts/Judges, and will assist them in seeking necessary treatment and service for the youth.

**The CCAA Part I:**
Assessments to establish treatment/medical recommendations have eight components (all components must be included in the standardized report as clinically indicated and appropriate):

I. Part I
   
   a. **Records Search** – A review and summarization of the youth’s records, to include, but not be limited to, past evaluations, past psychiatric treatment records, information from current providers, school records, child welfare records, juvenile probation and juvenile diversion records and other relevant historical information.

   b. **Collateral Contacts** – A review and summarization of any collateral contacts that are relevant to the comprehensive assessment. At a minimum, this shall include the child’s school, HHSS (Health and Human Services System) and/or caseworker, and past and present treatment providers.

   c. **Family Assessment** – A current assessment completed by an appropriately licensed provider, which addresses the family functioning, family dynamics and their impact on the youth’s treatment needs. The family assessment shall include all parents identified by the OJS P&S worker. If not, the assessment shall contain documentation as to why all parents identified were not included in the family assessment. The family assessment is based on a direct face-to-face interview conducted in a clinician’s office or in the youth’s home, pursuant to the contract
requirement of conducting at least 20 percent of the interviews in the youth’s home.

d. **CASI**—Completion of all 10 elements of the Comprehensive Adolescent Severity Inventory, which includes:
   1) Health information
   2) Stressful life events
   3) Education
   4) Drug/alcohol use
   5) Use of free time
   6) Peer relationships
   7) Sexual behavior
   8) Family/household members
   9) Legal issues and
   10) Mental health.

e. **Assessment**—A review of the first five components of the CCAA, an interview with the youth, an evaluation of current medication or recommendations for medication and its management, the completion of a Mental Status Exam, and a DSM (current version) diagnosis, if present

f. **Wellness Check/Health Check (EPSDT)**—A wellness check includes, but is not limited to the following:
   1) Physical description of the youth (i.e., hair and eye color, distinguishing marks, tattoos, etc.), height, weight, blood pressure, pulse, temperature, vision test, hearing test and medical history. The youth who receives the Wellness Check/Health Check will receive subsequent follow-up as deemed medically necessary by the medical authority.
   2) Any pertinent laboratory tests completed by medical professionals working within their scope of practice to determine whether the youth tests positive for drug usage (including marijuana, cocaine or methamphetamine usage); tuberculosis; or pregnancy. Include a full written explanation when these tests are not completed.
   3) Sexually Transmitted Disease (STD) testing, if ordered by medical staff.
   4) HIV testing is not required. However, if HIV testing is indicated, this should be noted in the recommendation.
   5) If a Wellness Check/Health Check has been conducted in the past 12 months, and it meets all the EPSDT requirements, it should be identified during the record search Component and included with the supporting documentation.
   6) A new Wellness Check/Health Check is not required if the current one completed within the last 12 months is representative of the youth’s medical situation.
7) If there has not been a Wellness Check/Health Check conducted in the past 12 months, one should be done during the 10-day residential or community-based evaluation.

8) If possible, it is preferable to have the Wellness Check/Health Check completed by the youth’s primary care physician and the result of the examination included with this assessment.

9) If this is not possible, a Wellness Check/Health Check should be conducted by a member of the CCAA contracted provider team.

g. **Psychological Testing and Other Mental Health Assessments** - Psychological testing and other mental health assessments, if clinically applicable and appropriate, shall be arranged and completed as part of the CCAA.

   1) Any additional testing/assessment shall be authorized/billed separately from the CCAA, but shall be considered part of the CCAA and completed under the direction of the Supervising Practitioner. This may include, but is not limited to, a Psychological Testing, Sex Offender Risk Assessment and Eating Disorder Assessment.

   2) The results of any additional testing/assessment shall be incorporated into the CCAA.

   3) Any additional testing/assessment shall be completed within the specified 10-day evaluation period.

h. **Standardized Report** - The standardized report should adhere to the following recommended format:

   1) Demographics
   2) Presenting problem/primary complaint
   3) Medical history and any current medical needs
   4) School/work/military history
   5) Alcohol/drug history summary
   6) Legal history (information from the Juvenile Justice System)
   7) Family/social/peer history-in home/in office
   8) Psychiatric/behavioral history-psychotropic medication
   9) Collateral information (family/friends/criminal justice/victim issues)
   10) Case formulation, i.e., how these conclusions were arrived at, what causes the youth to behave as he or she does, etc.
   11) Clinical impression
   12) Substance use disorder recommendations, if applicable. Include primary/ideal level of care recommendation, available level of care/barriers to ideal recommendation and youth/family response to recommendation
13) Mental health recommendations, if applicable. Include treatment needs and level of care (recommendations for youth and family according to Medicaid medical necessity guidelines); who needs to be involved in the treatment; areas needing further evaluation; and client/family response to recommendations.

14) If more than one recommendation is made, such as substance use disorder and mental health treatment or substance use disorder and conduct disorder, the Supervising Practitioner must identify how the two recommendations should be sequenced and coordinated.

15) Recommendations. The recommendations must be developed by all the practitioners participating in the CCAA, and signed by the Supervising Practitioner (psychologist or psychiatrist).

16) The Supervising Practitioner must complete all necessary requests for authorization, treatment referrals and written applications as required for services. A psychiatrist must complete the request for PRTF services.

17) The Supervising Practitioner shall also participate in all peer and reconsideration reviews associated with these requests, as appropriate.

18) Supporting Documentation. Include a list of records reviewed and identify the source of each, an organized summary of record search, and a list of collateral contacts by facility, contact persons and date contacted.

**Timelines for Completion of the Comprehensive Child and Adolescent Assessment.**

All eight components of the CCAA, as clinically indicated, including the standardized report with supporting documentation and any related psychological and other mental health assessment, shall be completed and delivered to the Magellan within 10 working days.

- Day one begins with the day following receipt of the request to complete the CCAA.
- The completed CCAA must be received by no later than 5:00 p.m. on the tenth day.

**CCAA Part II: Non-Treatment Recommendations/Evaluations OJS Evaluation**

The Health and Human Services System (HHSS) Office of Juvenile Justice (OJS)/Protection & Safety (P&S) Staff are responsible for completing Part II of the assessment, which is comprised of the following components.
1) OJS Initial Classification, which determines the level of supervision required.
2) OJS Risk Assessment, which identifies the client’s risk to re-offend, and includes, but is not limited to, the following:
   • Information pertaining to the number of prior arrests
   • Age at first arrest
   • Prior petition for auto theft or robbery
   • Prior out of home placements
   • Peer relationships
   • School truancy history
   • Educational achievement
   • Alcohol or drug problems, and
   • History of neglect.
3) HHSS Youth Needs Assessment, which identifies, but is not limited to,
   • The abilities of the family to be involved with the client, and includes information pertaining to substance use disorder of the parent
   • Conflict at home
   • Living situation
   • Parenting skills
   • Caretaker disabilities
   • Intra-family sex abuse (excluding the client)
   • Family criminality
   • Peer relationships
   • School behavior
   • Intellectual/educational deficits
   • Vocational education/employment
   • Substance use disorder of the youth.
4) Cover Letter, which summarizes the findings and recommendations of the entire evaluation.

The OJS/P&S worker shall coordinate and forward the assessment in its entirety to the court of jurisdiction. The OJS evaluation (Parts I & II) shall be completed within 30 calendar days.

**CCAA Evaluation Locations:**
There are two recommended locations for the CCAA. In most cases, Health and Human Services OJS/P&S shall determine whether a community-based or residential evaluation is most appropriate.

**Community-Based Evaluation:** The CCAA is completed in the youth’s home, the clinician’s office or another setting in the community where the youth normally resides. While the community-based evaluation is being completed, the youth resides in a setting in the community such as his/her home, shelter or detention.
A youth may be living in a locked facility such as Lancaster County Attention Center, Douglas County Youth Center, Sarpy County Detention Center, Wayne Detention Center and Scottsbluff County Detention Center.

**Residential Evaluation:** With prior authorization, the CCAA is completed in a residential facility provided or arranged by the contracted CCAA provider. A residential facility allows mental health professionals to observe the youth in a setting on a 24-hour basis, for a maximum of three days. Residential evaluations are conducted in a highly structured, staff secure, and duly licensed residential setting. Residential evaluations may include a maximum of three days board and room payment.

**Youth Sexual Offending Risk Assessment (SORA)**

**Purpose and Definition:**
The purpose of the Sexual Offending Risk assessment is to identify how mental health/substance use disorder diagnoses relate to sexual offending behavior and provide a sexual offending risk assessment to develop client treatment recommendations, if indicated. The complete Sexual Offending Risk Assessment must be available for other professionals, such as caseworkers, probation workers, physicians, and other health care consultants in compliance with HIPAA and other state and federal regulations for use in the development of appropriate intervention strategies. This is not a forensic evaluation but intended to guide treatment.

**Policy:**
The Sexual Offending Risk Assessment is available to individuals who are Medicaid Managed Care and aged 20 or younger. The SORA is not a forensic or court ordered evaluation rather it is based upon medical necessity established by a licensed clinical psychologist or psychiatrist upon completion of an initial diagnostic interview.

**Practitioner Requirements:**
Each part of the Sexual Offending Risk Assessment must be completed by a fully licensed clinician(s) acting within his/her scope of practice, which is enrolled with the Nebraska Division of Medicaid and Long-Term care as a provider of mental health services and contracted and credentialed to provide mental health services by Magellan.
Required Assessment Instruments:
The Sexual Offending Risk Assessment must include: a clinical interview of client and family members; include collateral sources and review of documentation; a diagnostic interview; and risk assessment instruments measuring both dynamic and static factors. Additional psychological testing for cognitive/adaptive functioning, behavior and personality may be requested on a case by case basis and would be required to be separately authorized by Magellan as medically necessary; however, psychological testing to perform sexual offense risk assessments will not be separately authorized.

Components Outline:
The Sexual Offending Risk Assessment is expected to include the following components
1) Demographic Information
2) Reason for Referral
3) List of Evaluation Procedures including
   a) clinical interview of client, family members (i.e. parents)
   b) Initial Diagnostic Interview
   c) collateral sources
   d) Reviewed documents (i.e. caseworker notes, legal documents, school records, treatment records, medical records, etc.)
   e) a summary review of previous psychological testing, if any (may include cognitive/adaptive functioning, behavior, personality measures)
   f) risk assessment instruments measuring both dynamic and static factors (i.e. ERASOR-2; ASO Questionnaire; Juvenile Risk Assessment Scale)
4) Psychosocial Information including:
   a) background information,
   b) family relationships and dynamics
   c) current situation
   d) social functioning
   e) school/academic history
   f) substance use history
   g) legal history,
   h) mental health treatment history,
   i) sexual offense history,
   j) trauma/victimization history
   k) personal strengths
5) Results of Assessment including:
   a) level of cognitive/adaptive functioning
   b) personality and behavior factors
   c) sexual offending risk assessment using both static and dynamic factors
   d) sexual misconduct patterns
   e) perception/understand of motivation/ empathy for victim
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f) current supervision and access to victim

6) Diagnostic Impression
7) Least Restrictive Treatment and Safety/Supervision Recommendations

Expectations for Completion of the SORA:
• Documentation expectations include a typed report which includes the components listed above resulting in treatment and placement recommendations. The report must be signed by all fully licensed clinicians who participated in the formation of the report including the Supervising Practitioner.

• A comprehensive Sex Offender Risk Assessment must include collateral contact information (with appropriate signed releases) with significant others or family members to gather relevant information about individual and family functioning and through collateral contacts with former and current healthcare providers, friends, and court contacts to verify medical history, substance usage, and legal history.

• This SORA includes information on the risk for re-offending, mental health, substance use disorder and is considered a comprehensive assessment

• With appropriate releases of information, it is expected that this assessment will be shared with other professionals involved in the client’s assessment and treatment.
• Addendums to the SORA are appropriate when the youth has had a subsequent offense and the assessing provider had completed a full risk assessment previously. In these cases, the provider must conduct an updated risk assessment and also update other pertinent information contained in the original / prior SORA(s). The original SORA must be attached to the addendum in order to provide a complete clinical assessment.

Psychological Testing

Purpose and Definition:
Psychological testing involves the culturally and linguistically competent administration and interpretation of standardized tests to assess a child’s/adolescent’s psychological or cognitive functioning.

• All testing must be pre-authorized by Magellan.
• Testing is virtually never needed on an emergency basis and, thus, requests for it can be reviewed and approved before it begins.
• Routine testing (such as sometimes requested by facilities for admission or regularly provided upon commencement of treatment) is not considered medically necessary.
Most disorders can be diagnosed through interview and observation. Psychological testing is considered when a diagnostic interview and behavioral observations are not able to differentially diagnose. Requests for psychological testing should include which elements of a diagnosis are in question and an explanation as to why these elements cannot be determined by an interview or through observation. Treatment plans should be based on problem analysis, not necessarily diagnosis. For example, knowing the “why now” and the precipitating events, which are essential to treatment planning, do not require psychological testing.

- Limited psychological testing may be approved for invasive and potentially life changing Medicaid covered surgeries and procedures.
- Testing may also be viewed as a potentially helpful second opinion for treatment failures and/or difficult to diagnose cases.

**Expectations for Completion of Psychological Testing:**
For psychological testing to be eligible for authorization, compliance with the following process is required:

- Requested tests must be standardized, valid and reliable. The most recent version of the test is to be utilized. The instrument must be age, developmentally, linguistically and culturally appropriate to the client.
- Testing requests must meet medical necessity criteria.
- Prior to testing, the client must be assessed by a licensed psychologist. In many cases, a diagnostic assessment is sufficient for the diagnosis and treatment of a mental health disorder without psychological testing.
- Authorized administration time for tests is customarily based on the times listed in *Tests in Print, Edition V*. If the requested test is not listed in this publication, or for self-administered tests lacking a range, then the times listed in the publishers’ catalog or alternative sources are used. The time authorized per test will be a maximum of one and one-half the time the standard time it takes to administer the test. The time authorized includes administration, observations, scoring, interpretation and report writing.

**Expectations for Completion of the Psychological Testing Report:**
Results of psychological testing should be summarized in a typed report that includes, at minimum: demographic information, dates of services, the presenting problem for which testing was administered, results of the testing, whether the provider believes that the testing produced valid results, an explanation of the results, diagnoses and recommendations derived from the testing. Up to two case conference codes (90887) are authorized to explain testing results to parents or guardians for members age 20 and younger.
B-5 Covered Mental Health and Substance Use Disorder Treatment Services

Medication Management

Purpose and Definition:
Medication management is the initial evaluation of the client’s need for psychotropic medications, the provision of a prescription as needed, and ongoing medical monitoring/evaluation related to the client’s use of the psychotropic medication.

Licensing/Accreditation:
- Providers of this service must be appropriately enrolled with Nebraska Medicaid
- Providers must be credentialed and contracted with Magellan Behavioral Health of Nebraska, Inc. as outlined in the Handbook Supplement
- Providers must maintain licensure as directed by the Nebraska Department of Health and Human Services. Providers will notify Magellan of all changes to licensure and submit copies of all current/active licenses to Magellan
- Organizations providing this service must be licensed, certified, or accredited through a national accreditation body such as The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF) or by the Council on Accreditation (COA). Providers will provide Magellan copies of all current/active accreditation certificates and the most recent accreditation site review report.

Features/Hours:
Outpatient medication management services must be provided in a confidential setting such as an office, clinic or other professional service environment. The service must be available during times that meet the need of the youth and their family to include after school, as well as evenings or weekends or both. Scheduled, routine medication management services should not interfere with the youth’s academic and extracurricular schedule. The service provider must assure that the youth and parent/caregiver has on-call access to a qualified professional whose scope of practice is to prescribe medication 24 hours a day, seven days a week. A recorded answering machine instructing the member to go to the emergency room does not meet this requirement.

Service Expectations:
- Medical evaluation
- Medication monitoring routinely and as needed
- Individual/parent/guardian education pertaining to the medication so they may make an informed decision for its use
• Coordinate care with all other medical and behavioral health providers. If the member / guardian does not consent to these coordination of care activities, or if the provider believes coordination of care is contra indicated, supporting documentation is required.
• Conduct an Initial Diagnostic Interview prior to initiating medication management.
• Staff providing medication management services will encourage the use of medications that do not require prior authorization. This assists members in maintaining ongoing adherence to a prescribed medication regimen. The preferred drug list is available at https://nebraska.fhsc.com/.

Staffing:
A Psychiatrist, or other practitioner qualified to prescribe and manage medication may provide this service. An Advanced Practice Registered Nurse (APRN), Physician Assistant (PA) or Nurse Practitioner (NP) is able to provide this service when practicing within the scope of their license and with appropriate supervision.
Client Assistance Program (CAP)

Purpose and Definition:
Client Assistance Programs are a short-term, solution-focused set of interventions to assist a client who is eligible for the Medicaid managed care benefit of mental health and/or substance use disorder services. Normally used prior to a diagnosis and assessment, this is a sub-clinical service; therefore it is issue driven and not a diagnostically driven service.

Licensing/Accreditation:
- Providers of this service must be appropriately enrolled with Nebraska Medicaid
- Providers must be credentialed and contracted with Magellan Behavioral Health of Nebraska, Inc. as outlined in the Handbook Supplement
- Providers must maintain licensure as directed by the Nebraska Department of Health and Human Services. Providers will notify Magellan of all changes to licensure and submit copies of all current/active licenses to Magellan
- Organizations providing this service must be licensed, certified, or accredited through a national accreditation body such as The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF) or by the Council on Accreditation (COA). Providers will provide Magellan copies of all current/active accreditation certificates and the most recent accreditation site review report.

Features/Hours:
Outpatient CAP services must be provided in a confidential setting such as an office, clinic, or other professional service environment. The service must be available during times that meet the need of the youth and their family to include after school, as well as evenings or weekends or both. CAP services should not interfere with the youth’s academic and extracurricular schedule. The client is eligible for up to five sessions per calendar year to assist a client in reducing or eliminating the current stressors that are interfering with the client’s daily living and well-being.

Service Expectations:
- Brief counseling or problem solving to resolve client identified issues.
- Behavioral health screening.
- Referral as appropriate.

Staffing:
Therapeutic interventions shall be provided by a licensed practitioner whose scope of practice includes mental health and/or substance use disorder treatment services that assist the client by empowering the client and client’s family to attain a more manageable level of functioning.
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Staff, acting within the scope of practice, will include:
- Licensed Mental Health Practitioner (LMHP)
- Provisionally Licensed Mental Health Practitioner (PLMHP)
- Licensed Independent Mental Health Practitioner (LIMHP)
- Licensed Psychologist
- Provisionally Licensed Psychologist
- Psychiatrist
- Advanced Practice Registered Nurse (APRN).

Outpatient Crisis

Purpose and Definition:
Outpatient Crisis services offer short-term, intense intervention aimed at assisting the individual and/or family experiencing a life-threatening or traumatic event, with perceived urgent/emergent conditions, or within two weeks of being discharged from a 24-hour treatment setting or partial hospitalization. Outpatient Crisis services are intended to assure that individuals and families receive immediate treatment intervention, when it is needed and where it is needed. For children and adolescents, active family involvement and/or family therapy are expected unless contraindicated. Services must be trauma informed and sensitive to potential personal safety risks such as suicidal intention.

Crisis services are available to children, adolescents and adult individuals eligible for Medicaid Managed Care and may be provided as individual and/or family therapy. In emergencies, the individual may obtain a crisis service, even if they have a current open authorization for therapy with another provider.

Licensing/Accreditation:
- Providers of this service must be appropriately enrolled with Nebraska Medicaid
- Providers must be credentialed and contracted with Magellan Behavioral Health of Nebraska, Inc. as outlined in the Handbook Supplement
- Providers must maintain licensure as directed by the Nebraska Department of Health and Human Services. Providers will notify Magellan of all changes to licensure and submit copies of all current/active licenses to Magellan
- Organizations providing this service must be licensed, certified, or accredited through a national accreditation body such as The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF) or by the Council on Accreditation (COA). Providers will provide Magellan copies of all current/active accreditation certificates and the most recent accreditation site review report.
Features/Hours:
Outpatient crisis services must be provided in a confidential setting such as an office, clinic or other professional service environment. The service must be available during times that meet the need of the youth and their family to include after school, as well as evenings or weekends or both. The service provider must assure that the youth and parent/caregiver has on-call access to a qualified mental health professional on a 24 hours a day, seven days a week basis.

Service Expectations:
Crisis treatment goals are identified by the youth and parent/caregiver.

The therapist/provider must coordinate care with the individual’s primary medical provider and the therapy provider if on-going therapy is authorized. If the member/guardian does not consent to these coordination of care activities, or if the provider believes coordination of care is contra indicated, supporting documentation is required.

The intervention/safety plan identifies the crisis with steps for further resolution, outlines an individualized safety plan for the client and/or family, and identifies additional formal and informal supports. The clinician will assist in making appropriate referrals.

Staffing:
Staff, licensed to practice in the State of Nebraska, enrolled with Nebraska Medicaid, contracted and credentialed with Magellan and acting within their scope may provide this service and includes:

- Licensed Mental Health Practitioner (LMHP)
- Provisionally Licensed Mental Health Practitioner (PLMHP)
- Licensed Independent Mental Health Practitioner (LIMHP)
- Licensed Psychologist
- Provisionally Licensed Psychologist
- Psychiatrist
- Advanced Practice Registered Nurse (APRN).

Case Conferences

Purpose and Definition:
A case conference is the sharing of clinical information about the client with the parents and/or legal guardians. It is a treatment intervention, must be identified in the client’s treatment plan and requires a progress note. The outcome is expected to improve the client’s condition. It is done face-to-face with the responsible person.

Policy:
Case conferences services are available to adolescent, and child members eligible for Medicaid Managed Care, younger than 19 years old, and may be provided to review results of psychological testing or to plan treatment interventions with parents/caregivers. Case conferences are limited to two units for psychological testing review with parents/caregivers.

**Licensing/Accreditation:**
- Providers of this service must be appropriately enrolled with Nebraska Medicaid
- Providers must be credentialed and contracted with Magellan Behavioral Health of Nebraska, Inc. as outlined in the Handbook Supplement
- Providers must maintain licensure as directed by the Nebraska Department of Health and Human Services. Providers will notify Magellan of all changes to licensure and submit copies of all current/active licenses to Magellan
- Organizations providing this service must be licensed, certified, or accredited through a national accreditation body such as The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF) or by the Council on Accreditation (COA). Providers will provide Magellan copies of all current/active accreditation certificates and the most recent accreditation site review report.

**Features/Hours:**
Case conferences may be conducted face-to-face in the office, home, school or other appropriate location based upon parents/care giver location and setting where intervention is to occur.

**Service Expectation:**
The case conference is part of the client’s treatment plan. Treatment interventions are based on needs identified in the Initial Diagnostic Interview (or subsequent assessments) and focused on specific treatment goals inclusive of the culture, expectations and needs as identified by the youth and parent/caregiver. Case Conferences are an active treatment intervention and not simply an exchange of information between the provider and caregiver(s).

**Staffing:**
Staff, licensed to practice in the State of Nebraska, enrolled with Nebraska Medicaid, contracted and credentialed with Magellan and acting within their scope of practice may provide this service and include:
- Licensed Mental Health Practitioner (LMHP)
- Provisionally Licensed Mental Health Practitioner (PLMHP)
- Licensed Independent Mental Health Practitioner (LIMHP)
- Licensed Psychologist
- Provisionally Licensed Psychologist
- Psychiatrist
• Advanced Practice Registered Nurse (APRN).

Outpatient Psychotherapy

Purpose and Definition:
Outpatient individual psychotherapy is for the treatment of mental health symptoms related to a DSM (current version) psychiatric diagnosis through scheduled therapeutic visits between the therapist and the youth. Outpatient psychotherapy is expected to improve active symptoms of the identified client that significantly interfere with the youth’s functioning in at least one life domain (e.g., familial, social, occupational, educational, etc.). The goals, frequency and duration of outpatient treatment will vary according to the client’s needs and response to treatment. Individuals other than the identified client may participate in the individual session with the identified client to assist in achieving the client’s treatment goals. Individual therapy must meet medical necessity criteria and be developmentally appropriate for the age of the client.

Outpatient group psychotherapy is active treatment of a DSM (current version) psychiatric disorder through scheduled treatment interventions with a common goal in the context of a group setting. A group is described as at least three individual clients and no more than 12 clients facilitated by a licensed practitioner. The focus of outpatient group psychotherapy treatment is to improve the youth’s ability to function as well as alleviate symptoms related to their diagnosis that may significantly interfere with their functioning. The goals, frequency, and duration of outpatient group treatment will vary according to individual needs and response to treatment.

Groups that are primarily focused on providing education or prevention or support do not meet the definition of outpatient group psychotherapy for Medicaid and, as such, are not reimbursable.

Outpatient family psychotherapy is a therapeutic encounter between the licensed treatment professional, the youth and the nuclear family that includes at least one parent/caregiver. The parent/caregiver must be an adult identified as having a current and long-term future commitment with the youth (e.g., guardian, foster parents, extended family with an established relationship and long-term future commitment). The specific objective of active treatment must be to increase the functional level of the family. This therapeutic intervention must be provided with the identified client who has a current DSM (current version) diagnosis and family members present.

Outpatient family psychotherapy services are based upon the following guidelines:
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- One family psychotherapy session may be utilized on any particular day per family.
- One family psychotherapy session is available for families even though the family may have multiple Medicaid eligible individuals with a psychiatric and/or substance use disorder diagnosis. Only one Medicaid eligible family session may be utilized for family psychotherapy even though another identified Medicaid eligible individual may be present in the family psychotherapy session.

Reimbursement is available for family therapy without the member present (90846). This service type should only be used in the extreme case where it is clinically contraindicated to have the identified member present for the family therapy session and should not be the primary intervention used. Family therapy without the member present should be a purposeful intervention identified in the treatment plan and must have corresponding progress notes in the chart documentation. This service is not meant to provide reimbursement for information sharing between the provider and family members or to provide other non-covered services (parent education, couples counseling) or to provide services to non-covered individuals (individual therapy to a non-Medicaid covered parent(s).

Policy:
Outpatient mental health services are available to youth age 20 and younger. For clients who present with co-occurring mental health and substance use disorder symptoms and diagnoses, the provider must refer to the ASAM Criteria (current version). Providers are responsible to refer to the ASAM criteria (current version). The provider must also adhere to the service descriptions and clinical guidelines for Outpatient Level 1, as well as the clinical guidelines identified in this service description.

Licensing/Accreditation:
- Providers of this service must be appropriately enrolled with Nebraska Medicaid
- Providers must be credentialed and contracted with Magellan Behavioral Health of Nebraska, Inc. as outlined in the Handbook Supplement
- Providers must maintain licensure as directed by the Nebraska Department of Health and Human Services. Providers will notify Magellan of all changes to licensure and submit copies of all current/active licenses to Magellan
- Organizations providing this service must be licensed, certified, or accredited through a national accreditation body such as The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF) or by the Council on Accreditation (COA). Providers will provide Magellan copies of all current/active accreditation certificates and the most recent accreditation site review report.
Features/Hours:
Outpatient psychotherapy services must be provided in a confidential setting such as an office, clinic, the youth’s home or other professional service environment. The service must be available, during times that meet the need of the youth and their family to include after school, as well as evenings or weekends or both. Scheduled, routine psychotherapy services should not interfere with the youth’s academic and extracurricular schedule. The service provider must assure that the youth, and parent/caregiver has on-call access to a mental health provider on a 24 hour a day, seven days per week basis.

Service Expectations:
- The Initial Diagnostic Interview and subsequent assessment(s) by the Supervising Practitioner must be conducted by a psychiatrist, psychologist, or licensed independent mental health practitioner (LIMHP) prior to the beginning of treatment. Other independently licensed practitioners, such as APRNs, may complete an IDI as the treating provider but cannot serve in the role of Supervising Practitioner.
- Assessment should be ongoing with treatment and used to inform and establish time-limited and measurable, symptom focused treatment goals and objectives.
- Ongoing suicide/risk assessment should be conducted each time the member is seen and appropriately documented in the clinical record. Members who become homicidal, suicidal and unable to conduct activities of daily living, are referred to the appropriate level of care. Assessing for other unsafe behaviors that have been a focus of treatment and/or have occurred in the past, such as property destruction, domestic violence and repeat sexual offenses are also part of this ongoing risk assessment each time the member is seen. Asking client if these problems are present may be necessary and appropriate, however the client’s statements alone are not sufficient. Coordination of the safety plan with member’s natural supports and community resources must be included throughout the clinical record as member makes progress and moves to discharge to the least restrictive level of care.
- Treatment interventions should be based on the comprehensive assessment, and focused on specific treatment goals inclusive of the culture, expectations and needs as identified by the youth and parent/caregiver.
- The therapist/licensed clinician should routinely screen for relapse or possible new substance use to rule out barriers to progress related to their DSM (current version) diagnoses, symptoms and document these results in the clinical record. If substance use concerns develop then interventions such as education or, with the member’s permission, coordination with the member’s natural supports and community resources regarding substance use effects on symptoms and/or progress should be utilized. If these interventions do not bring about a change in the client’s condition, a full substance use assessment is referred or completed.
• The individual treatment/discharge plan is reviewed and updated by the youth, parent/caregiver and the Supervising Practitioner as frequently as medically indicated, but at a minimum of every 90 calendar days, and signed by all participants.
• Psychotherapy must be developmentally appropriate for the age of the youth.
• Provide consultation and/or referral for general medical, psychiatric, psychological, and psychopharmacology needs.
• The therapist/licensed clinician must assist the youth and parent/caregiver in identification and utilization of community resources and natural supports which must be identified in the discharge plan.
• The therapist/provider must coordinate care with the individual’s primary care physician (PCP) and any other mental health or substance use disorder treatment providers. If the member / guardian does not consent to these coordination of care activities, or if the provider believes coordination of care is contra indicated, supporting documentation is required.
• When other individuals are participating with the client in the individual treatment sessions, the focus and documentation must be based on the client’s individual treatment goals outlined in the treatment plan.
• If group therapy is the primary intervention, individual and/or family therapy must be available as needed to support progress or address issues not amenable to group intervention.
• Family psychotherapy services must:
  • Address issues related to the functioning of the entire family unit. Be family-focused with goals and objectives that are clearly stated in the treatment plan.
• Family psychotherapy services are at least 60-minute therapy sessions.

Staffing:
Staff, licensed to practice in the State of Nebraska, enrolled with Nebraska Medicaid, contracted and credentialed with Magellan and acting within their scope may provide this service and include:
• Licensed Mental Health Practitioner (LMHP)
• Provisionally Licensed Mental Health Practitioner (PLMHP)
• Licensed Independent Mental Health Practitioner (LIMHP)
• Licensed Psychologist
• Provisionally Licensed Psychologist
• Psychiatrist
• Advanced Practice Registered Nurse (APRN)
• Licensed Alcohol and Drug Counselor (LADC).

Supervising Practitioner (individuals meeting the requirements of a Supervising Practitioner are not required to have additional supervision to provide the therapy service)
• Psychiatrist
• Licensed Clinical Psychologist
• Licensed Independent Mental Health Practitioner (LIMHP).

**Supervising Practitioner Involvement:**
- Supervision must be provided within the scope of practice of the individual Supervising Practitioner.
- Provide face-to-face service to the member at least annually or as often as medically necessary.
- Complete the Initial Diagnostic Interview prior to beginning therapy.
- Provide the therapist with recommendations for a course of treatment if medically necessary.
- Provide a supervisory contact with the therapist every 30 days or more often as necessary. Direct face-to-face contact is preferred; however, communication may occur by telephone. Supervisory contact will include:
  a) A review of the treatment recommendations developed in the Initial Diagnostic Interview by the therapist and the Supervising Practitioner.
  b) Update on the status of the client, including progress achieved, barriers that impaired progress in treatment, to include and critical incidents which involve patient safety or others such as aggression or self-harm (The incident may have been reported at the time of the incident, depending on severity.)
  c) Review of the treatment/recovery plan and the progress notes provided by the therapist.
  d) Determination of the plan for ongoing treatment, with any change in focus or direction of treatment.
  e) Review of the discharge plan and the recommendation for changes in discharge as necessary.
  f) Changes in the discharge plan are documented in the client’s clinical record.

**Community Treatment Aide (CTA)**

**Purpose and Definition:**
Community Treatment Aide (CTA) services are supportive and psycho-educational interventions provided primarily in the client’s natural environment. Natural environment is primarily the client’s home but may also include a foster home, school or other appropriate community locations conducive for the delivery of CTA services per the service definition.

Community Treatment Aide (CTA) services are designed to assist the client with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their mental illness. CTA services shall
enhance the client’s and caregiver’s ability to manage the client’s mental health and substance use disorder symptoms. Activities included shall have the intention of achieving the identified goals or objectives as set forth in the client’s individualized treatment plan.

The service is delivered by a highly skilled, educated and trained non-licensed staff person under the direction and supervision of a licensed practitioner who simultaneously provides family and/or individual therapy on a regular basis to the client and the client’s caregiver/family.

CTA services provided in the school are to advise school staff (teachers, Para-educators, etc.) on behavior management techniques and mental health strategies designed specifically for the identified youth to address his/her mental health/substance use disorder symptoms. These services include consultation with the teacher (or Para-educator) for behavior health issues, not educational issues, and are not intended to replace the Para-educator role. CTA services may be provided in school when medically necessary to generalize treatment gains across systems, and to model intervention effectiveness. The CTA also may serve in a communicator role between school, parent/caregiver and therapist/licensed clinician for the purpose of maintaining continuity between systems and sharing of pertinent information. It is expected that CTA involvement will be reduced as usual school personnel gain necessary skills to manage the youth’s symptoms in the school environment. All services must meet medical necessity criteria for continuation.

CTA services provided in a foster care or group home setting are to advise the primary caregiver(s) on behavior management techniques and mental health strategies designed specifically for the identified youth to address his/her mental health symptom, and to model appropriate and effective interventions for the primary caregiver(s). This service is consultative, and not intended to replace the regular caretaker role. The CTA also may serve in a communicator role between the usual caregiver and therapist/licensed clinician for the purpose of maintaining continuity between systems and sharing of pertinent information. It is expected that CTA involvement will be reduced as the usual caretaker(s) gains necessary skills to address the youth’s symptoms in their living environment. All services must meet medical necessity criteria for continuation.

**Licensing/Accreditation:**
- Providers of this service must be appropriately enrolled with Nebraska Medicaid.
- Providers must be credentialed and contracted with Magellan Behavioral Health of Nebraska, Inc. as outlined in the Handbook Supplement.
• Providers must maintain licensure as directed by the Nebraska Department of Health and Human Services. Providers will notify Magellan of all changes to licensure and submit copies of all current/active licenses to Magellan.

• Organizations providing this service must be licensed, certified, or accredited through a national accreditation body such as The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF) or by the Council on Accreditation (COA). Providers will provide Magellan copies of all current/active accreditation certificates and the most recent accreditation site review report.

Features/Hours:
CTA services may be provided primarily in the youth’s home or foster home but may also be provided in treatment-appropriate community settings with the parent or caregiver present. Community Treatment Aid services shall not be used in place of a school aid. The CTA service must be available during times that meet the need of the youth and their family to include after school, evenings or weekends or both. Scheduled, psychotherapy and CTA services should not interfere with the youth’s academic and extracurricular schedule. The service provider must assure that the youth and parent/caregiver have on-call access to a mental health provider 24 hours, seven days per week.
Service Expectations:

- The CTA treatment plan must be updated with the family, the therapist and Supervising Practitioner every 90 days or sooner as medically necessary.
- Treatment interventions should be based on the comprehensive assessment and focused on specific treatment goals inclusive of the culture, expectations and needs as identified by the youth and parent/caregiver.
- The CTA staff is expected to provide interventions which may include: parent instruction, de-escalation techniques, behavioral management techniques, coping skills, social and life skills development, child development, medication compliance and relapse prevention.
- The therapist/licensed clinician and CTA staff must assist the family in identification and utilization of community resources and natural supports which must be identified in the discharge plan.
- The CTA should bill a H0036 in 15 minute units for the CTA direct services.
- The therapist/licensed clinician must develop a youth and parent/caregiver goal-driven, comprehensive treatment and discharge plan with the Supervising Practitioner and in collaboration with the CTA, the youth and the parent/caregiver prior to the initiation of treatment. The treatment plan must be signed by all members of the treatment team (youth, parent/caregiver, therapist/licensed clinician, Supervising Practitioner, CTA and other supportive individuals) identified by the youth and parent/caregiver and team.
- The therapist/licensed clinician is required to provide family and individual therapy as recommended in the active treatment plan. If youth are admitted to CTA programs and are unable to participate in individual, group and family therapy or these interventions are contra-indicated to address the treatment needs of the youth, medically necessary CTA services utilizing other appropriate therapeutic interventions, such as behavior modification interventions or therapy, may still be rendered under the direction of a licensed clinician. The therapist/licensed clinician and CTA staff must maintain orderly documentation of all Community Treatment Aide services provided and shall have documented evidence of every other week care coordination and collaboration activities.
- The Supervising Practitioner must provide monthly supervision and direction to the CTA therapist. This contact may be by telephone and must be documented in the member’s treatment record.
- The CTA therapist must communicate with and document coordinated services with any other mental health/substance provider for the family or individual family members. Documented coordination of services is required as part of the overall treatment plan and is not billable as a separate Medicaid service. Documentation must describe the coordination of all services in the treatment record and reviews by the Supervising Practitioner.
Staffing:
Only accredited agencies will be allowed to use provisionally licensed clinicians to provide the therapy and CTA supervision for this service. Ongoing supervision by the agency is expected. Staff, licensed to practice in the State of Nebraska, enrolled with Nebraska Medicaid, contracted and credentialed with Magellan and acting within their scope may provide this service and include:

- Licensed Mental Health Practitioner (LMHP)
- Provisionally Licensed Mental Health Practitioner (PLMHP)
- Licensed Independent Mental Health Practitioner (LIMHP)
- Licensed Psychologist
- Provisionally Licensed Psychologist
- Psychiatrist
- Advanced Practice Registered Nurse (APRN)
- Licensed Recreational Therapist
- Licensed Alcohol and Drug Counselor (LADC)
- Provisionally Licensed Alcohol and Drug Counselor (PLADC).

Supervising Practitioner Involvement: (Psychiatrist, Licensed Clinical Psychologist and LIMHP are independent practitioners who may fill the role of Supervising Practitioner as well as providing the required therapy without additional supervision for CTA programming.)

The responsibilities of the Supervising Practitioner include but are not limited to the following:

- Provide monthly supervision to the CTA therapist.
- Complete an Initial Diagnostic Interview immediately before or at the time of admission as required for the family therapy component of CTA.
- Provide supervision and direction on an ongoing basis, as needed, along with the CTA program director
- Prescribe and order all treatment interventions based upon the assessment.

Program/Clinical Director:
This practitioner may be a licensed physician with a specialty in psychiatry, Licensed Mental Health Practitioner (LMHP), licensed registered nurse (RN), licensed APRN, LMHP or a licensed psychologist. The program/clinical director shall be a fully licensed practitioner contracted and credentialed with Magellan who is providing services within his/her scope of practice and licensure and has two years of professional experience in mental health and/or substance use disorder treatment of individuals younger than age 21. The practitioner has professional experience in a similar treatment setting to that of a program director position. The program director may also act as the CTA licensed therapist in small agency CTA programs.
The responsibilities of the Program/Clinical Director include but are not limited to the following:

- Oversees, implements and coordinates all treatment services and activities provided within the program
- Continually incorporates new clinical information and best practices into the program to assure program effectiveness and viability
- Oversees the process to identify, respond to and report crisis situations 24 hours per day, seven days per week
- Responsible (in conjunction with a Supervising Practitioner, as needed) for the program’s clinical management
- Assures quality organization and management of clinical records, other program documentation and confidentiality.

**Therapist/licensed clinician:** (LMHP, LIMHP, PLMHP, Licensed Psychologist, Provisionally Licensed Psychologist, APRN, Licensed Psychiatrist)

The clinician providing psychotherapy services for youth, and oversight and supervision to the CTA in the treatment program, must be a licensed mental health practitioner or provisional licensed mental health practitioner (if working within an accredited organization or credentialed by Magellan in an underserved area) and operating within his or her scope of practice and program requirements.

The role and responsibilities of the therapist includes but are not limited to the following:

- Reports to the Program/Clinical Director and Supervising Practitioner (as required) for clinical and non-clinical guidance and direction
- Communicates treatment issues to Supervising Practitioner as needed
- Provides individual and family psychotherapy
- Provides supervision to the CTA, guiding the treatment plan implementation in the home/living environment; reviewing, approving and signing all CTA progress notes
- Participates in the treatment team (under the direction of the Supervising Practitioner as required) to develop treatment plans for individuals in their care
- Provides input to the interdisciplinary team and attends treatment team meetings
- Provides continuous and ongoing assessment to assure the clinical needs of the youth/parent/caregiver are met. This includes transitioning of youth to other treatment and care settings.

**Community Treatment Aides:**

Community Treatment Aides must have either:

- Have a bachelor’s degree in psychology, social work, child development or a related field and the equivalent of one year of full-time experience in direct
child/adolescent services or mental health and/or substance use disorder services. Equivalent time in graduate studies may substitute for work experience; or

- Have two years post-high school education in the human services or related fields and a minimum of two years' experience in direct child/adolescent services or mental health and/or substance use disorder services.

Must be employed by or contracted within the same agency as the therapist/licensed clinician, unless an exception has been granted by Magellan. The role and responsibilities of the CTA include but are not limited to the following:

- Has a clear understanding of the treatment plan and discharge plan
- Supervision and rehabilitation of basic personal care and activities of daily living through training the youth and the usual caregiver
- Promoting improvement in the youth's social skills and relationship skills through training, and education of the youth and the usual caregiver
- Teaching and instructing the caregiver in crisis de-escalation techniques
- Teaching and modeling for the youth and the youth’s caregiver in appropriate behavioral treatment interventions and techniques
- Teaching and modeling for the youth’s caregiver in the appropriate coping skills to manage dysfunctional behavior
- Providing information about medication compliance and relapse prevention
- Teaching and modeling proper and effective parenting practices needed to manage the youth’s mental health and/or substance use disorder symptoms.

**Staff Ratios:**

- Supervising Practitioner to individual served: adequate to meet program expectations;
- Program/Clinical Director to individual served: as needed to meet all service expectations;
- Therapist to CTA/individuals served: as needed to meet all service expectations;
- CTA to individual/individuals served: typically one per youth and parent/caregiver, but one CTA may serve multiple clients.

**CTA Additional Training:**

All Community Treatment Aides must receive 40 hours of pre-service training which minimally will include:

- Family centered practice
- Trauma-informed care
- De-escalation techniques and aggression management
- Crisis intervention strategies
- Behavior management planning and technique implementation
The role of medication in psychiatric treatment and common psychotropic medications used in the treatment of children/adolescents
- Effective verbal and written communication
- Discipline and structure in the home
- Restraint and seclusion policies and procedures
- Common child/adolescent psychiatric diagnosis and treatment modalities
- Cardiopulmonary resuscitation (CPR) and first aide
- Safety and protection for home-based staff
- Confidentiality/HIPAA
- Professional, personal and family boundaries
- Parenting techniques and understanding in depth the program supported parent training model
- Child development
- Knowledge of the specific regulations for the mandatory reporting of abuse and neglect, according to state statute
- Knowledge of substance use disorders and the appropriate treatment interventions.

The community treatment aide must demonstrate competency in these topics prior to providing services. This competency record must be kept in the community treatment aide’s personnel file. A minimum of 12 additional hours of ongoing, similar training are required annually. The agency must have proof of an evaluation of competency on an annual basis in the CTA’s personnel file.

### Intensive Outpatient (IOP) Child / Adolescent

**Purpose and Definition:**

Intensive Outpatient Programs (IOP) for children and adolescents provide interdisciplinary, multi-modal, structured treatment in an outpatient setting. Services are based on the individual’s medical need and must meet medical necessity criteria. Such programs are less intensive than partial hospital and day treatment programs but significantly more intensive than traditional outpatient psychotherapy and/or medication management. The goals, frequency and duration of the intensive outpatient program shall vary according to the individual needs of the client and the client’s response to the day-to-day treatment intervention. Treatment services may also be appropriately used to prevent the need for a higher level of care. Treatment services may also be appropriately used to transition a client from higher levels of care and may be appropriately used to prevent the need for higher levels of care.

One Supervising Practitioner shall be responsible for the clinical direction of the program and for the individualized treatment of each client participating in the
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Program. Programs shall identify a coverage Supervising Practitioner to serve the program in the unforeseen absence of the designated Supervising Practitioner due to illness or vacations.

The program philosophy shall be to provide an aggression-free environment. Providers shall identify and teach de-escalation strategies to their staff prior to allowing staff to provide direct care services.

Dual-licensure is required for licensed practitioners providing IOP Services when co-occurring conditions (e.g., mental health/substance use disorder diagnoses) occur.

IOP programs may be developed with a particular focus to treat a mental health and other, co-occurring diagnoses such as substance use disorder or eating disorders, or dysfunctions such as sexual offending. IOPs could also specialize in meeting the treatment needs for transition age (17-20) youth diagnosed with a mental health and/or other disorder, focusing specifically on the youth’s additional need to develop independent living skills.

For clients who present with co-occurring mental health and substance use disorder symptoms and diagnoses, the provider must refer to the ASAM Criteria (current version). Providers are responsible to refer to the ASAM Criteria (current edition). The provider must also adhere to the service descriptions and medical necessity guidelines for intensive Outpatient Level 2.1 as well as the medical necessity guidelines identified in this service description.

**Licensing/Accreditation:**
- Providers of this service must be appropriately enrolled with Nebraska Medicaid
- Providers must be credentialed and contracted with Magellan Behavioral Health of Nebraska, Inc. as outlined in the Handbook Supplement
- Providers must maintain licensure as directed by the Nebraska Department of Health and Human Services. Providers will notify Magellan of all changes to licensure and submit copies of all current/active licenses to Magellan
- Organizations providing this service must be licensed, certified, or accredited through a national accreditation body such as The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF) or by the Council on Accreditation (COA). Providers will provide Magellan copies of all current/active accreditation certificates and the most recent accreditation site review report.

**Features/Hours:**
The program shall be available at a minimum of nine scheduled hours per week for at least three hours of availability per day. The program shall be offered at a
minimum of three times per week but may also be available up to seven days per week.

The program shall identify an on-call system of licensed practitioners available for crisis management when the client is not in the program’s scheduled hours and/or the program is not in session.

The program shall be flexible in offering a menu of treatment services to meet the client’s individual needs and offer a schedule of participation for the client in the program. The program shall identify an on-call system of licensed practitioners available for crisis management when the client is not in the program’s scheduled hours and/or the program is not in session.

Treatment shall be offered during the day but may be scheduled before and after a work schedule and/or school schedule and also may occur on the weekend.

**Service Expectations:**

- An initial treatment plan will be developed at admission based upon the Supervising Practitioner’s Initial Diagnostic Interview, which is completed prior to or within 24 hours of admission to IOP and prior to the delivery of services. If the Supervising Practitioner of the IOP program had completed an assessment with the youth prior to admission to the IOP program and that assessment is still clinically relevant to the youth’s condition, no additional assessment is needed.

- The Supervising Practitioner may identify additional assessments in his/her recommendations or for other medical consultations, if these are medically necessary. The IOP provider shall assist the client in completing any other assessments to determine clarification of diagnoses or to identify other conditions which may impact the client’s mental health and/or substance use disorder condition.

- Medication management must be available to all clients participating in an IOP service when medication is prescribed by an appropriately licensed practitioner. This service shall be medically and clinically necessary for the mental health and/or substance use disorder requiring treatment. The practitioner providing medication management shall consult with the program periodically and may bill for all directly delivered medication management services separate from the payment to the program for IOP services.

- Interdisciplinary team which includes the youth and their family develops and maintains a signed family-centered, outcome-focused comprehensive treatment and discharge plan within 14 calendar days of admission.
• The interdisciplinary team consists of the youth, family, therapist/licensed clinician, Supervising Practitioner and other supportive individuals identified by the youth and their family.

• Treatment interventions must be outcome focused based on the comprehensive assessment, treatment goals, culture, expectations and needs as identified by the youth and their family.

• The individual treatment/recovery and discharge plan is reviewed by the treatment team as frequently as medically indicated, but at a minimum of every 30 calendar days, and reviewed, approved and signed by the Supervising Practitioner and the additional interdisciplinary team members.

• IOP interventions must include: ongoing assessment, individual, group, and family psychotherapy and psycho-educational services. If youth are admitted to Intensive Outpatient programs and are unable to participate in individual, group or family therapy or these interventions are contra-indicated to address the treatment needs of the youth, other, covered therapeutic interventions (for example, behavior modification interventions or therapy) may be used to most appropriately meet the needs of the youth.

• Psycho-educational and rehabilitation services such as life skills, community support building, leisure skill building, time management, pre-vocational skill building and health education (e.g., nutrition, hygiene, medications, personal wellness, etc.) may also be a part of the treatment program provided by a non-licensed staff.

• Family interventions must relate to the youth's treatment plan and includes skill building regarding mental health and substance use disorder symptom management. This may include: de-escalation techniques, behavioral management techniques, coping skills, social and life skills development, child development, medication compliance and relapse prevention.

• Provide consultation and/or referral for general medical, psychiatric, psychological, vocational, educational services and psychopharmacology needs.

• Therapists of youth with more than one mental health/substance use disorder provider must communicate with and document coordinated services with any other mental health/substance provider for the family or individual family members. Documented coordination of services is required as part of the overall treatment plan and is not billable as a separate Medicaid service. Documentation must describe the coordination of all services in the treatment record, and reviews by the Supervising Practitioner.
• Discharge planning starts at admission and must be included in the treatment plan and all treatment plan reviews. Prior to discharge the IOP staff must facilitate, confirm and document that contacts are made with the identified community service or treatment providers identified in the discharge plan.

• The service must provide or otherwise demonstrate that youth and family have on-call access to a licensed mental health provider 24 hours a day, seven days per week.

• Clients whose symptoms include uncontrolled disruptive behavior shall have de-escalation and anger management identified in the initial treatment plan, and measures shall be taken to aggressively enforce and manage those behaviors at the earliest time possible. IOP Direct Care Staff shall be aware of safety issues unique to each child and provide safety intervention.

• The program shall establish a relationship with other programs which offer emergency services and have a written plan for immediate admission or readmission for appropriate more intensive services, as necessary.

• The therapist/provider must coordinate care with the individual’s PCP and any other mental health or substance use disorder treatment providers. If the member / guardian does not consent to these coordination of care activities, or if the provider believes coordination of care is contra indicated, supporting documentation is required.

Staffing:
Staff, licensed to practice in the State of Nebraska, enrolled with Nebraska Medicaid, contracted and credentialed with Magellan and acting within their scope may provide this service and include:

• Licensed Mental Health Practitioner (LMHP)
• Provisionally Licensed Mental Health Practitioner (PLMHP)
• Licensed Independent Mental Health Practitioner (LIMHP)
• Licensed Psychologist
• Provisionally Licensed Psychologist
• Psychiatrist
• Advanced Practice Registered Nurse (APRN)
• Licensed Recreational Therapist
• Licensed Alcohol and Drug Counselor (LADC)
• Non-licensed Direct Care Staff (provide psycho-educational and rehabilitative services only).

Staffing Requirements:
Dual-licensure is required for licensed practitioners providing IOP Services when co-occurring conditions (e.g., mental health/substance use disorder diagnoses) occur.

**Supervising Practitioner Involvement:** (Psychiatrist; Licensed Clinical Psychologist, LMHP)

The responsibilities of the Supervising Practitioner include but are not limited to the following:

- Complete an Initial Diagnostic Interview prior to or within 24 hours of admission and prior to service delivery. If the Supervising Practitioner of the IOP program completed an assessment prior to admission, it shall serve as the admission assessment provided that:
  - The information in the assessment is current and provides sufficient recommendations for the IOP team to develop an initial treatment plan
- Provide a face-to-face treatment service at least every 30 days or as medically necessary (this service includes a diagnostic assessment or a review of the effectiveness of the treatment plan)
- Directly participate in and supervise the development of the initial treatment plan within 14 days of admission (the recommendations of the IOP Supervising Practitioner serves as the treatment plan until the treatment plan is developed by the 14th day following admission)
- Update the goal-directed treatment plan with the interdisciplinary team every 30 days
- Monitor and supervise the treatment services delivered
- Review the progress and benefit of the services to the client and adjust the treatment plan as necessary
- Review and supervise discharge planning with each treatment plan review and provide direction for adjustment as necessary. The Supervising Practitioner must coordinate care with the individual’s PCP and any other mental health or substance use disorder treatment providers. If the member / guardian does not consent to these coordination of care activities, or if the provider believes coordination of care is contra indicated, supporting documentation is required.

**Program/Clinical Director:** LMHP, Psychiatric RN, APRN, LMHP, Licensed Psychologist, Dual Licensure, e.g., LMHP/LADC or LMHP/PLADC, is required for Dual IOP programs.

The Program Director must be fully licensed by the State of Nebraska, providing services within his/her scope of practice and licensure, and have two years of professional experience in the psychiatric treatment of children and adolescents. This clinician must have professional experience in a treatment setting similar to the IOP.
The responsibilities of the Program/Clinical Director include but are not limited to the following:

- Oversees, implements and coordinates all treatment services
- Consistently incorporates new clinical information and best practices into the program to assure program effectiveness and viability
- Oversees the process to identify, respond to, and report crisis situations 24 hours per day, seven days per week
- Provides clinical management and supervision of the program in conjunction and consultation with the Supervising Practitioner
- Assures confidentiality, quality, organization and management of clinical records and other program documentation
- Applies and supervises the gathering of outcome data and determines the effectiveness of the program for the clients served

**Therapist/licensed clinician:** (LMHP, LIMHP, PLMHP, LADC, Licensed Psychologist, Provisionally Licensed Psychologist, APRN, Licensed Psychiatrist). The clinician(s) providing services for youth in the treatment program must be operating within their scope of practice and meeting program requirements.

The role and responsibilities of the therapist include but are not limited to the following:

- Reports to the Program/Clinical Director and Supervising Practitioner for clinical and non-clinical guidance and direction
- Communicates treatment issues to Supervising Practitioner as needed
- Implements treatment plan by providing individual, group, family psychotherapy and/or substance use disorder counseling
- Provides assistance to direct care staff in implementing the treatment plan
- Assists to develop and update active treatment and discharge plans for individuals in their care in conjunction with the interdisciplinary team
- Provides input to the interdisciplinary team and attends treatment team meetings
- Provides continuous and ongoing assessment to assure the clinical needs of the youth and parents/caregivers are met. This includes transitioning of youth to other treatment and care settings, or other types of supports as necessary.

**Direct Care Staff:** The direct care staff shall meet one of the following requirements:

a) A bachelor’s degree or higher in psychology, sociology or related human service field, plus a minimum of one year work experience or graduate studies in direct child/adolescent services or mental health and/or substance use disorder services
b) Two years of post-high-school education in the human services field, plus a minimum of two years of experience or training in the human services field with demonstrated skills and competencies in treatment of youth with mental illness,

Basic requirements of Direct Care Staff include:

- Successfully complete the initial program training and the agency’s competency check
- Demonstrate skill and competency in the treatment of clients with mental health and substance use disorders prior to delivery of services
- Shall pass the child abuse check, adult abuse registry and motor vehicle screens
- Complete specific training for behavioral management and update the training as required by the program
- Understand de-escalation techniques and demonstrate the ability to implement those techniques effectively
- Understand that restraint and seclusion are not appropriate for this level of care.

Direct Care Staff perform the following functions in IOP services:

- Implement treatment plan components related to psycho-educational activities and interventions to help clients develop social, recreational and other independent living skills as appropriate. Psycho-educational therapy services include, but are not limited to:
  - Crisis intervention plan and aftercare planning
  - Social skills building
  - Life survival skills
  - Substance use disorder prevention Intervention
  - Self-care services
  - Therapeutic recreational activity
  - Medication education and medication compliance groups
  - Health care issues group (e.g., nutrition, hygiene, personal wellness)

- Provide continual care and supervision to clients in the program during the IOP session
- Report all crisis or emergency situations to the program/clinical director or to the program’s designee in the absence of the program/clinical director
- Understand the program’s philosophy regarding behavior management and apply its philosophy in daily interactions with the clients in care.

Staff Ratios:
• All staffing shall be adequate to meet the individualized treatment needs of the client and meet the responsibilities of each staff position as outlined in the staffing requirements.

• The Supervising Practitioner’s hours shall be adequate to provide the necessary direct services and the administrative responsibilities as the supervisor of the IOP program and the individualized care for each of the clients.

• The program director shall have adequate hours to fulfill the expectations and responsibilities of the program/clinical director’s position description, as described in this document.

• The ratio of therapists/licensed clinicians is at least 1:15.

• Direct Care staff: adequate to proved psycho-educational experiences safely and effectively.

Day Treatment

Purpose and Definition:
Day Treatment provides medically necessary, community-based, coordinated set of individualized treatment services to children/adolescents with mental health and/or co-occurring mental health and substance use disorder diagnoses whose symptoms are interfering with their daily functioning in a typical school, work, and/or home environment and need the additional structured treatment interventions of this level of care. Day Treatment is a community-based service that can be as intense as is medically necessary based upon member need, this service includes diagnostic, medical, psychiatric, psychosocial, psycho-therapeutic and adjunctive treatment modalities provided in a structured setting/manner. Day Treatment programs can be authorized to provide as many units of therapy and structured time as is medically necessary to maintain a youth in the community. Day Treatment leads to the attainment of specific goals through treatment interventions and allows for transition of the child/adolescent to an outpatient level of care. This level of care is intended for children/adolescents who reside in the community with their parent(s)/caregiver(s), in the family home or in a group home placement. It provides stabilization during the day, weekends and/or after-school hours as medically necessary for youth who are at risk to be placed in a higher level of care in order to address current symptoms, or who are transitioning from an acute or residential level of care to a home environment. Family involvement, including family therapy, from the beginning of treatment is extremely important and, unless contraindicated, should occur at least weekly. Coordination of school performance is an important component of treatment planning as is involvement with school personnel to monitor the ongoing impact of treatment and facilitate constructive ways of working with the youth.
A day treatment setting shall provide a well-organized, supportive therapeutic environment where clients can achieve progress in accomplishing the goals of their individualized, active treatment plan. The expectation is that all the clients have the ability to partake in treatment programming with the least number of disruptions and distractions and must be expected to benefit from treatment in a structured environment.

Day Treatment Services achieve specific goals through a group of individualized treatment interventions and services. Individualized treatment is based upon an active treatment plan and a specific plan for discharge from Day Treatment when the treatment goals have been met.
Licensing/Accreditation:
- Providers of this service must be appropriately enrolled with Nebraska Medicaid
- Providers must be credentialed and contracted with Magellan Behavioral Health of Nebraska, Inc. as outlined in the Handbook Supplement
- Providers must maintain licensure as directed by the Nebraska Department of Health and Human Services. Providers will notify Magellan of all changes to licensure and submit copies of all current/active licenses to Magellan
- Organizations providing this service must be licensed, certified, or accredited through a national accreditation body such as The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF) or by the Council on Accreditation (COA). Providers will provide Magellan copies of all current/active accreditation certificates and the most recent accreditation site review report.

Features/Hours:
The program shall be available a minimum of three hours per day and a minimum of five days per week. Providers are encouraged to develop programs of greater flexibility offered up to 12 hours per day and seven days per week.

The program shall be flexible in offering a menu of treatment services to meet the client's individual needs and offer a schedule of participation for the client in the program.

The program shall identify an on-call system of licensed practitioners available for crisis management when the client is not in the program's scheduled hours and/or the program is not in session.

The provider of Day Treatment services shall bill psychotherapy treatment services separately from rehabilitation or psycho-educational services. The client may attend the number of hours as authorized based on medical necessity criteria. Rehabilitation or psycho-educational services are authorized and billed in 15 minute increments.

Treatment shall be offered during the day but may be scheduled before and after a work schedule and/or school schedule and also may occur on the weekend.

The following mandatory services and frequency of services are minimum requirements:
- Weekly individual psychotherapy and/or substance use disorder counseling
- Daily (up to seven per week) group psychotherapy and/or substance use disorder counseling
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- Weekly family psychotherapy and/or family substance use disorder counseling
- Arrangements for pharmacology, psychological, and dietary services
- Nursing staff to meet the medical needs of the members in treatment
- Medication management.

Other services may include:
- Crisis intervention plan and aftercare planning
- Social skills building
- Life survival skills
- Substance use disorder prevention intervention
- Self-care services
- Recreational therapy
- Medication education and medication compliance groups and
- Health care issues group (may include nutrition, hygiene and personal wellness).

Service Expectations:

- An initial treatment plan will be developed at admission based upon the Supervising Practitioner’s Initial Diagnostic Interview, which is completed prior to or within 24 hours of admission to Day Treatment. If the Supervising Practitioner of the Day Treatment program had completed an assessment of the youth prior to admission to the Day Treatment program and that assessment is still clinically relevant to the youth’s condition, no additional assessment is needed.

- A nursing assessment must be completed by an RN or APRN on the first day of admission.

- The Supervising Practitioner may identify additional assessments in his/her recommendations or for other medical consultations, if these are medically necessary. The Day Treatment provider shall assist the client in completing any other assessments to determine clarification of diagnoses or to identify other conditions which may impact the client’s mental health and/or substance use disorder condition.

- Medication management must be available to all clients participating in a Day Treatment service when medication is prescribed by an appropriately licensed practitioner. This service shall be medically and clinically necessary for the mental health and/or substance use disorder requiring treatment. The practitioner prescribing the medication, whether within the program or outside of the program, shall consult with the program periodically and may bill for all
directly delivered medication management services separate from the payment to the program for Day Treatment services.

- The administration and management of medication and youth/family medication education (e.g., expected benefits, potential side effects, potential interactions, dosage, obtaining/filling prescriptions, etc.) are required for Day Treatment programs.

- Interdisciplinary team which includes the youth and their family develops and maintains a signed family-centered, outcome-focused comprehensive treatment and discharge plan within 10 calendar days of admission.

- The interdisciplinary team consists of the youth, family, therapist/licensed clinician, Supervising Practitioner and other supportive individuals identified by the youth and their family.

- Treatment interventions must be outcome focused based on the comprehensive assessment, treatment goals, culture, expectations and needs as identified by the youth and their family.

- The individual treatment/recovery and discharge plan is reviewed by the treatment team as frequently as medically indicated, but at a minimum of every 30 calendar days, and reviewed, approved, and signed by the Supervising Practitioner and the additional interdisciplinary team members.

- Day Treatment interventions must include: ongoing assessment, individual, group, and family psychotherapy and psycho-educational services. If youth are admitted to Day Treatment programs and are unable to participate in individual, group or family therapy or these interventions are contra-indicated to address the treatment needs of the youth, other, covered therapeutic interventions (for example, behavior modification interventions or therapy) may be used to most appropriately meet the needs of the youth.

- Psycho-educational and rehabilitation services such as life skills, community support building, leisure skill building, time management, pre-vocational skill building and health education (e.g., nutrition, hygiene, medications, personal wellness, etc.) may also be a part of the treatment program provided by a non-licensed staff.

- Family interventions must relate to the youth’s treatment plan and includes skill building regarding mental health and substance use disorder symptom management. This may include: de-escalation techniques, behavioral management techniques, coping skills, social and life skills development, child development, medication compliance and relapse prevention.

- Provide consultation and/or referral for general medical, vocational and educational services.

- Provide or contract for the provision of pharmaceutical services under the supervision of a registered pharmacy consultant.
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- Provide or contract for the provision of dietary services under the supervision of a registered dietician consultant, based upon the client’s individual dietary needs if meals are served.
- Provide medically necessary psychological diagnostic services by a licensed psychologist or provisionally licensed psychologist under the supervision of a fully licensed psychologist. Medical necessity is documented in the treatment record by the program’s supervising psychiatrist.
- Therapists must communicate with and document coordinated services with any other mental health/substance and/or medical providers for the family or individual family members. Documented coordination of services is required as part of the overall treatment plan and is not billable as a separate Medicaid service. Documentation must describe the coordination of all services in the treatment record and reviews by the Supervising Practitioner.
- Discharge planning starts at admission and must be included in the treatment plan and all treatment plan reviews. Prior to discharge the Day Treatment staff must facilitate, confirm and document that contacts are made with the identified community service or treatment providers identified in the discharge plan.
- Provide information and skill development for youth and/or family in regards to accessing community resources and natural supports that could be used to help facilitate youth/family efficacy and increase youth function without the support of ongoing Day Treatment.
- The service must provide or otherwise demonstrate that youth and family have on-call access to a licensed mental health provider 24 hours a day, seven days per week.
- Clients whose symptoms include uncontrolled disruptive behavior shall have de-escalation and anger management identified in the initial treatment plan, and measures shall be taken to aggressively enforce and manage those behaviors at the earliest time possible. Day Treatment Direct Care Staff shall be aware of safety issues unique to each child and provide safety intervention.
- The program shall establish a relationship with other programs which offer emergency services and have a written plan for immediate admission or readmission for appropriate more intensive services as necessary.
- The program philosophy shall be to provide an aggression-free environment. Providers shall identify and teach de-escalation strategies to their staff prior to allowing staff to provide direct care services.
- Procedures such as seclusion and restraint to manage the treatment milieu are not permitted in day treatment programs. Staff aggression, both verbal and physical, shall not be tolerated in the program environment and the program shall aggressively manage staff behavior through education and training measures.
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Staffing:
Staff, licensed to practice in the State of Nebraska, enrolled with Nebraska Medicaid, contracted and credentialed with Magellan and acting within their scope may provide this service and include:

- Licensed Mental Health Practitioner (LMHP)
- Provisionally Licensed Mental Health Practitioner (PLMHP)
- Licensed Independent Mental Health Practitioner (LIMHP)
- Licensed Psychologist
- Provisionally Licensed Psychologist
- Psychiatrist
- Advanced Practice Registered Nurse (APRN)
- Licensed Recreational Therapist
- Licensed Alcohol and Drug Counselor (LADC)
- Non-licensed Direct Care Staff (provide psycho-educational and rehabilitative services only).

Staffing Requirements:
Dual-licensure is required for licensed practitioners providing Day Treatment Services when co-occurring conditions (e.g., mental health/substance use disorder diagnoses) occur.

Supervising Practitioner Involvement: (Physician, with a specialty in psychiatry)
The responsibilities of the Supervising Practitioner include but are not limited to the following:

- Complete an Initial Diagnostic Interview within 24 hours of admission and prior to service delivery (EXCEPTION: If the Supervising Practitioner of the Day Treatment program completed an assessment prior to admission, it shall serve as the admission assessment provided that:
  - The information in the assessment is current and provides sufficient recommendations for the Day Treatment team to develop an initial treatment plan)
- Directly participate in and supervise the development of the initial treatment plan at admission or within 24 hours (the recommendations of the Day Treatment Supervising Practitioner serves as the treatment plan until the treatment plan is developed by the 10th day following admission).
- Assume accountability for the care of the client at the time of admission and during the entire Day Treatment stay.
- Update the goal-directed treatment plan with the interdisciplinary team at least every 30 days.
- Monitor and supervise the treatment services delivered.
- Review the progress and benefit of the services to the client and adjust the treatment plan as necessary.
• Review and supervise discharge planning with each treatment plan review and provide direction for adjustment as necessary. The Supervising Practitioner must ensure that care is coordinated with the individual’s PCP and any other mental health or substance use disorder treatment providers.
• Provide a face-to-face assessment/service to the client at least every 14 days (or more often as medically necessary).
• Provide crisis management including supervision and direction to the staff to resolve any crisis of the client’s condition.
• Monitor and supervise an aggressive plan to transition the client from the program into less intensive treatment services (as medically necessary).

Program/Clinical Director:
(LMHP, Psychiatric RN, APRN, LMHP, Licensed Psychologist. Dual Licensure [e.g., LMHP/LADC or LMHP/PLADC] is required for Dual Day Treatment programs). The Director must be a clinician fully licensed by the State of Nebraska, who is providing services within his/her scope of practice and licensure, and has two years of professional experience in the psychiatric treatment of children and adolescents. This clinician must have professional experience in a treatment setting similar to the Day Treatment program. Individuals who meet the criteria to act as the Supervising Practitioner may not hold both the Supervising Practitioner and Program Director roles for a single program at the same time.

The responsibilities of the Program/Clinical Director include but are not limited to the following:
• Continually incorporates new clinical information and best practices into the program to assure program effectiveness and viability
• Oversees the process to identify, respond to and report crisis situations 24 hours a day, seven days a week
• Provides clinical management of the program in conjunction and consultation with the Supervising Practitioner
• Assures confidentiality, quality, organization and management of clinical records and other program documentation
• Applies and supervises the gathering of outcome data and determines the effectiveness of the program for the clients served
• Oversees, implements and coordinates all treatment services and activities provided within the program.

Therapist/licensed clinician: (LMHP, LIMHP, PLMHP, LADC, Licensed Psychologist, Provisionally Licensed Psychologist, APRN, Licensed Psychiatrist) The clinician(s) providing services for youth in the treatment program must be operating within their scope of practice and meeting program requirements. The role and responsibilities of the therapist include but are not limited to the following:
• Reports to the Program/Clinical Director and Supervising Practitioner for
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clinical and non-clinical guidance and direction
• Communicates treatment issues to the Supervising Practitioner as needed
• Implements the treatment plan by providing individual, group, family psychotherapy and/or substance use disorder counseling
• Assists to develop/update treatment and discharge plans for individuals in their care in conjunction with the interdisciplinary team
• Provides assistance to direct care staff in implementing the treatment plan
• Attends treatment team meetings to review the course of treatment and modify the treatment plan and interventions accordingly
• Provides continuous and ongoing assessment to assure the clinical needs of the youth and parent(s)/caregiver are met, including transitioning of youth to other treatment and care settings, or other types of supports as necessary.

Registered Nurse: (RN or APRN):
Nursing services must be provided by a registered nurse licensed by the state in which he or she practices. The nurse must operate within his or her scope of practice. The nurse should have documented experience and training in the treatment of youth.

The responsibilities of the registered nurse include but are not limited to the following:
• Reports to the Program/Clinical Director for programmatic guidance
• Relates to the psychiatrist and medical physician as necessary regarding medical, psychiatric and physical treatment issues
• Provides nursing assessments
• Is a member of the interdisciplinary treatment team
• Provides medical interventions within the scope of practice as necessary
• Manages the storage and delivery of medication as necessary
• Oversees medication, client health education
• Supports special treatment procedures as defined by program requirements and state and federal regulations.

Direct care/Behavioral Technician: The direct care staff shall meet one of the following requirements:
• A bachelor’s degree or higher in psychology, sociology or related human service field, plus a minimum of one year work experience or graduate studies in direct child/adolescent services or mental health and/or substance use disorder services
• Two years of post-high school education in the human services field, plus a minimum of two years of experience or training in the human services field with demonstrated skills and competencies in treatment of youth with mental illness.
Basic requirements of Direct Care Staff include:

- Complete the initial program training and successfully complete the agency’s competency check
- Demonstrate skill and competency in the treatment of clients with mental health and substance use disorders prior to delivery of services
- Shall pass the child abuse check, adult abuse registry and motor vehicle screens
- Complete specific training for behavioral management and update the training as required by the program
- Understand de-escalation techniques and demonstrate the ability to implement those techniques effectively
- Understand that restraint and seclusion are not appropriate for this level of care.

Direct Care Staff perform the following functions in Day Treatment services:

- Implement treatment plan components related to psycho-educational activities and interventions to help clients develop social, recreational and other independent living skills as appropriate. Psycho-educational therapy services include, but are not limited to:
  - Crisis intervention plan and aftercare planning
  - Social skills building
  - Life survival skills
  - Substance use disorder prevention intervention
  - Self-care services
  - Therapeutic recreational activity
  - Medication education and medication compliance groups
  - Health care issues group (e.g., nutrition, hygiene, personal wellness)
- Provide continual care and supervision to clients in the program during the Day Treatment session
- Report all crisis or emergency situations to the program/clinical director or to the program’s designee in the absence of the program/clinical director
- Understand the program’s philosophy regarding behavior management and apply its philosophy in daily interactions with the clients in care.

**Staffing Ratios**

Providers shall use the following rules and ratios when staffing Day Treatment Service programs (ratios listed here may need to be increased if some treatment interventions are delivered outside of the program’s physical location or due to level of acuity):
All staffing shall be adequate to meet the individualized treatment needs of the client and meet the responsibilities of each staff position as outlined in the staffing requirements.

The Supervising Practitioner’s hours shall be adequate to provide the necessary direct services and the administrative responsibilities as the supervisor of the day treatment program and the individualized care for each of the clients.

The Program Director shall have adequate hours to fulfill the expectations and responsibilities of the program/clinical director’s description in this document.

Registered Nurse hours shall be adequate to provide the necessary nursing services to all clients admitted to the program and to meet all health care needs of the client during the client’s day treatment service episode.

The minimum ratio of therapists/licensed practitioners to clients served shall be at least 1:12.

The minimum ratio of direct care staff to clients served shall be at least 1:6.

Professional Resource Family Care (PRFC)

Purpose and Definition:
PRFC is intended to serve as crisis stabilization option for a family in order to avoid psychiatric inpatient and institutional treatment of the client by utilizing a co-parenting approach provided in a surrogate family setting.

During the time the professional resource family is supporting the client, there is regular contact with the client’s family to prepare for the client’s return and to support his/her ongoing needs as part of the family. It is expected that the client, family and professional resource family are integral members of the client’s individual treatment team. PRFC programs perform the following functions:

- Promotes improvement in the client’s social skills and family/peer relationships skills through training and education of the client and the usual caregiver.
- Teaches the caregivers or parents crisis and de-escalation techniques.
- Teaches and models appropriate behavioral treatment interventions and techniques to the client and the client’s caregiver or parents.
- Teaches and models appropriate coping skills to manage dysfunctional behavior to the client and the client’s caregiver or parents.
- Teaches and models proper and effective parenting practice to biological parents or the client’s primary caregiver.
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- Provides information about medication compliance and relapse prevention to the prescribing and/or Supervising Practitioner.
- Provides training and rehabilitation of basic personal care and activities of daily living by training the client and the usual caregiver or parent.
- Helps the client develop positive peer relationships.
- Works with the family to explore community resources in the client's and families' natural setting.

PRFC parents are supported and guided by a PRFC team and agency under the direction of a PRFC supervisor. The PRFC team is responsible for supporting and supervising the work of the surrogate parents, and ensuring coordination and collaboration between the member family and the surrogate parents. This family collaboration is a necessary and essential function of this family rehabilitation model.

Providers shall review all general requirements identified in 471 NAC 32-001.01 and comply with these general requirements.

PRFC services shall be provided under the direction of the PRFC supervisor who is to provide support and consultation to the treatment team and the PRFC specialist. PRFC supervisor activities shall be performed by a licensed practitioner whose scope of practice includes mental health services as defined in 471 NAC 32-001.04 who is acting within his/her scope of practice.

Licensing/Accreditation:
- Providers of this service must be appropriately enrolled with Nebraska Medicaid
- Providers must be credentialed and contracted with Magellan Behavioral Health of Nebraska, Inc. as outlined in the Handbook Supplement
- Providers must maintain licensure as directed by the Nebraska Department of Health and Human Services. Providers will notify Magellan of all changes to licensure and submit copies of all current/active licenses to Magellan
- Organizations providing this service must be licensed, certified, or accredited through a national accreditation body such as The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF) or by the Council on Accreditation (COA). Providers will provide Magellan copies of all current/active accreditation certificates and the most recent accreditation site review report.

Features/Hours:
PRFC is a 24-hour treatment program operating seven days per week. Family Rehabilitation functions performed by the professional resource care agency include, but are not limited to the following:
• Promotes improvement in the client’s social skills and family/peer relationships skills through training and education of the client and the usual caregiver
• PRFC staff must be available to provide interventions 24 hours per day. Planned and crisis respite services must be available for the member and for the surrogate parents. The agency’s program must provide or otherwise demonstrate that members and Professional Resource Family have on-call access to program staff 24 hours a day, seven days a week
• Teaches the caregiver crisis and de-escalation techniques
• Teaches and models appropriate behavioral treatment interventions and techniques to the client and the client’s caregiver
• Teaches and models appropriate coping skills to manage dysfunctional behavior to the client and the client’s caregiver
• Teaches and models proper and effective parenting practice to biological parents or the client’s primary caregiver
• Provides information about medication compliance and relapse prevention to the prescribing and/or Supervising Practitioner
• Provides training and rehabilitation of basic personal care and activities of daily living by training the client and the usual caregiver
• Helps the client develop positive peer relationships
• Works with the family to explore community resources in the client’s and families’ natural setting
• Provides 24-hour supervision.

Therapeutic passes (leave days) are an essential part of the treatment for client/families involved in PRFC. The therapeutic passes must be included as part of the treatment plan as they become appropriate. Documentation of the client’s continued need for PRFC must follow overnight therapeutic passes. NMMCP will reimburse for up to 14 authorized therapeutic leave days during the course of the client’s PRFC stay.

Service Expectations
• All referral information will be shared with the prospective PRFC family prior to placement.
• The Supervising Practitioner for the program must complete an Initial Diagnostic Interview prior to or within 24 hours. If the Supervising Practitioner of the PRFC program had completed an assessment with the youth prior to admission to the PRFC program and that assessment is still clinically relevant to the youth’s condition, no additional assessment is needed
• The Supervising Practitioner will also provide a face-to-face treatment intervention with the client at least every 14 calendar days after admission. The treatment plan will accordingly be updated each 14 days or more often as medically necessary.
• When aggressive and self-injurious behaviors have been noted in the assessment, the initial treatment plan will include effective approaches for all staff to manage these behaviors.

• Within seven days of admission, the comprehensive treatment plan shall be developed by the established interdisciplinary team of staff providing services for each client. Each treatment team member shall sign and indicate their attendance and involvement in the treatment team meeting.

• Treatment interventions should be outcome focused based on the comprehensive assessment, treatment goals, culture, expectations and needs as identified by the youth and their family.

• Complete additional assessments and screenings as determined by the Supervising Practitioner. Assessment must take place as an ongoing activity throughout the treatment episode.

• The PRFC surrogate parents, client and client’s biological family or caregiver, and legal guardian shall be included as treatment planning members in the initial plan and in the update plan to update treatment goals.

• The progress notes shall contain a concise assessment of the client/family’s progress and recommendations for revising the treatment plan, as indicated by the client/family’s condition, and discharge planning.

• The PRFC program shall facilitate the creation of support networks for treatment families; these may include formal groups, informal meetings and the development of “buddy” systems.

• Services provided to clients shall include communication and coordination with the family and/or legal guardian. Coordination with other services should occur as needed to achieve the treatment goals. All coordination services shall be documented in the client’s clinical record.

• Provide treatment in the PRFC home.

• Respite care shall be available at both planned and crisis times. The respite care provider shall be trained according to the standards set by the PRFC program and approved by Medicaid or its designee. The respite care providers shall be informed of the client/family treatment plan and supervised in their implementation of specific in-home strategies.

• The provider must coordinate discharge planning with the Magellan Care Manager.

• Adjunctive therapies such as life skills, community support building, leisure skill building, time management, pre-vocational skill building and health education (e.g., nutrition, hygiene, medications, personal wellness, etc.) may also be a part of the treatment program.
• Family interventions must relate to the youth’s treatment plan and includes skill building regarding mental health and substance use disorder symptom management. This may include: de-escalation techniques, behavioral management techniques, coping skills, assisting the youth with social and life skills development, child development, medication compliance and relapse prevention.

• Provide consultation and/or referral for general medical, psychiatric, psychological, vocational, educational services and psychopharmacology needs.

• It is the provider’s responsibility to coordinate with other treating professionals for discharge referrals.

• Discharge planning starts at admission and must be included in the treatment plan and all treatment plan reviews.

**Staffing:**
Staff, licensed to practice in the State of Nebraska, enrolled with Nebraska Medicaid, contracted and credentialed with Magellan and acting within their scope may provide this service and include:

- Licensed Mental Health Practitioner (LMHP)
- Provisionally Licensed Mental Health Practitioner (PLMHP)
- Licensed Independent Mental Health Practitioner (LIMHP)
- Licensed Psychologist
- Provisionally Licensed Psychologist
- Psychiatrist
- Advanced Practice Registered Nurse (APRN)
- Licensed Recreational Therapist
- Licensed Alcohol and Drug Counselor (LADC)
- Non-licensed Family Care Staff (provide psycho-educational and rehabilitative services only).

**Staffing Requirements:**
All staff must demonstrate skill and competency in the treatment of clients with mental health and substance use disorders prior to the delivery of services.

All staff must pass background checks with child abuse, sex offender, adult abuse, motor vehicle registers.

Staff must include:

- Supervising Practitioner (Psychiatrist; Licensed Clinical Psychologist)
- PRFC Supervisor (Fully licensed clinician: LMHP, psychologist, RN with a master’s degree in psychiatric nursing, counseling or mental health related field, psychiatrist)
- Licensed clinician for family therapy
• PRFC Specialist (minimum BS/BA in behavioral health field; MS/MA in behavioral health field preferred)
• Professional Resource Family (surrogate family)
• Respite Professional Resource Family
• Consultants may be utilized as needed.

The PRFC Supervisor is to provide support and consultation to the treatment team and the PRFC specialist. PRFC supervisor activities shall be performed by a licensed practitioner whose scope of practice includes mental health services as defined in 471 NAC 32-001.04 who is acting within his/her scope of practice.

PRFC Supervising Practitioner Responsibilities include:
• Assume accountability to direct the care of the member at the time of admission
• Complete an Initial Diagnostic Interview prior to or within 24 hours of admission and prior to service delivery (EXCEPTION: When the PRFC Supervising Practitioner completed an assessment prior to admission, it shall serve as the admission assessment provided that:
  o The information in the assessment is current and provides sufficient recommendations for the PRFC team to develop an initial treatment plan)
• Provide a face-to-face service to the member at least every 14 days to include a diagnostic assessment or a review the effectiveness of the treatment plan
• Be physically present at Treatment Team meetings at least every 14 days or more often as medically necessary, to participate in and supervise Treatment Planning.

PRFC Supervisor responsibilities include, but are not limited to:
• PRFC Specialist supervision: The PRFC supervisor shall provide regular support and guidance to the PRFC staff through regular supervisory meetings and informal contact as needed. This PRFC supervisor to specialist ratio shall be flexible to accommodate for the variables such as severity of clients served or by the experience/qualifications of the caseworker staff, however shall be adequate to meet the supervision needs of a specialist and support needs of the PPRFC surrogate parents.
• Treatment planning: The PRFC supervisor is a member of the treatment team and shares the responsibilities of developing the plan. She or he also evaluates progress reports and updates.
• Crisis on-call: The PRFC supervisor provides coordination and back-up to ensure that 24-hour on-call crisis intervention services are available and delivered to surrogate parents and biological families or caregivers.
• Other responsibilities: May include, but are not limited to:
  • Case management
  • Case assessment
• Parent support and consultation
• Clinical and administrative supervision of staff
• Surrogate parent recruitment
• Orientation
• Training and selection
• Youth intake and placement
• Record keeping, and
• Program evaluation.

**PRFC Specialist responsibilities** include, but are not limited to:
• Under the direction of the Supervising Practitioner and the PRFC supervisor, the PRFC specialist takes primary day-to-day responsibility for leadership of the treatment team. The PRFC specialist organizes and manages all team meetings and team decision making. The PRFC specialist takes an active role in identifying goals and coordinating treatment services provided to clients.
• The PRFC specialist provides information and training to treatment team members who may not be familiar with the PRFC model. The PRFC specialist prepares these individuals to work with surrogate parents and client families in a manner which is supportive of their roles. The PRFC specialist also prepares them to work with the team in a manner consistent with PRFC practices and values.
• Treatment planning: The PRFC specialist takes primary responsibility for the preparation of each client/family’s written comprehensive treatment plan and the written updates of the plan. The PRFC specialist seeks to inform and involve other team members, surrogate parents and the client family in this process.
• Support/consultation to surrogate parents: The PRFC specialist shall provide regular support and technical assistance to the surrogate parents in their implementation of the treatment plan and with regard to their other responsibilities. The fundamental components of technical assistance shall be the design or revision of in-home treatment strategies, including proactive goal setting and planning, the provision of ongoing child-specific skills training and problem solving during home visits.

**Surrogate Parent Qualifications:**
Each agency shall employ a PRFC Specialist who shall provide training and support to the surrogate parents. Surrogate parents shall meet the following qualifications:

• Have a high school diploma or equivalent
• Be age 21 or older
• Have a minimum of two years experience working with children, be equivalently qualified by education in the human services field, or have a combination of work experience and education with one year of education substituting for one year of experience
• Pass the child abuse check, adult abuse registry and motor vehicle screens
• Each surrogate parent shall be supported by a PRFC Agency with appropriate clinical supervision, training and staffing
• Understand de-escalation techniques and demonstrate the ability to implement those techniques safely and effectively.

**Staffing Ratios:**
The preferred maximum number of clients that may be assigned to a single PRFC specialist is 10 individuals or 10 sets of siblings. Flexibility within this standard is possible and shall be considered on an individual program basis.

The number of client/families assigned to a PRFC specialist is a function of:
• The size/density of the geographic area
• The array of job responsibilities assigned
• The difficulty of the population served.

**PRFC Surrogate Parent Training:**
PRFC parents must receive extensive pre-service training, including the basic foster parent/agency based training, and at least 20 additional hours of training related to mental health/substance use disorder issues. Training topics must address:
• De-escalation techniques
• Crisis intervention strategies
• Behavior management planning and techniques
• The role of medication in psychiatric treatment
• Discipline and structure in the home
• Common psychotropic medications used in the treatment of children
• Common child/adolescent psychiatric diagnoses and their treatment
• Handling psychiatric emergencies
• The role of the foster parent on the treatment team
• Physical restraint techniques, their indicators and contra-indicators, if allowed.

PRFC parents must receive additional 12 hours of ongoing training on an annual basis.

The PRFC specialist shall provide regular support and technical assistance to the surrogate parents in their implementation of the treatment plan and with regard to their other responsibilities. The fundamental components of technical assistance shall be the design or revision of in-home treatment strategies, including proactive goal setting and planning, the provision of ongoing child-specific skills training and problem solving during home visits.
In addition the PRFC agency shall provide the following to the PRFC surrogate parents:

- Emotional support and relationship building for the client and surrogate parents
- The sharing of information and general training to enhance professional development
- Assessment of the client’s progress
- Assessment of safety issues
- A minimum of weekly contact by phone or in person with the surrogate parent of each client family on his/her caseload
- Visiting the treatment home to meet with at least one PRFC parent no less than twice per month (more often as is necessary).
Therapeutic Group Home (ThGH)

Purpose and Definition:
ThGH’s deliver an array of clinical, treatment and related services, including psychiatric supports, integration with community resources and skill-building taught within the context of a home-like setting. ThGH treatment shall focus on reducing the severity of the behavioral health issues that were identified as the reasons for admission. Most often, targeted behaviors relate directly to the client’s ability to function successfully in the home and school environment (e.g., compliance with reasonable behavioral expectations, safe behavior and appropriate responses to social cues and conflicts).

The goal of a Therapeutic Group Home is to maintain the client’s connections to his or her community yet receive and participate in a more intensive level of treatment in which the client lives safely in a 24-hour setting. The emphasis of a Therapeutic Group Home is to restore the client to an improved level of functioning in order that the client may live and function in a less restrictive level of care. Therapeutic Group Homes are facilities specifically designed not to resemble institutions that allow a small population of clients to live in a home-like environment with an organized, professional staff who deliver safety, supervision, rehabilitation services and treatment services.

Treatment shall:
- Focus on reducing the behavior and symptoms of the mental health and/or substance use disorder that necessitated the removal of the client from his or her usual living situation
- Increase developmentally appropriate, normative and pro-social behavior in clients who are in need of out-of-home placement
- Transition clients from Therapeutic Group Homes to home- or community-based living with outpatient treatment (e.g., individual and/or family therapy).

Therapeutic Group Homes are community-based services that are family-centered, culturally competent and developmentally appropriate.

ThGH services are authorized when the client meets medical necessity criteria for this level of care and it is determined that less intensive levels of treatment are unsafe or unsuccessful and the client meets medical necessity criteria. ThGH services are provided on a 24 hours a day basis with vision/oversight by the Program Director and Supervising Practitioner.
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Licensing/Accreditation:
- Providers of this service must be appropriately enrolled with Nebraska Medicaid
- Providers must be credentialed and contracted with Magellan Behavioral Health of Nebraska, Inc. as outlined in the Handbook Supplement
- Providers must maintain licensure as directed by the Nebraska Department of Health and Human Services. Providers will notify Magellan of all changes to licensure and submit copies of all current/active licenses to Magellan
- Organizations providing this service must be licensed, certified, or accredited through a national accreditation body such as The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF) or by the Council on Accreditation (COA). Providers will provide Magellan copies of all current/active accreditation certificates and the most recent accreditation site review report.

Features/Hours:
The ThGH must provide 21 hours of active and rehabilitation treatment that will include, but not be limited to:

- Three hours of weekly Individual Psychotherapy, Substance Use Disorder Counseling and/or Group Psychotherapy and/or Substance Use Disorder Counseling
- Twice monthly Family Psychotherapy and/or Family Substance Use Disorder Counseling
- Psycho-educational groups and individual psycho-educational therapy services may include, but are not limited to:
  - Crisis intervention plan and aftercare planning
  - Social skills building
  - Life survival skills
  - Substance use disorder prevention intervention
  - Self-care services
  - Recreational activity
  - Medication education and medication compliance groups
  - Health care issues group (may include nutrition, hygiene and personal wellness).

The program must have formal arrangement for access to:
- Nursing care (24 hours per day)
- Psychological services
- Pharmacy services
- Dietary services.
The following optional services may also be provided:

- Recreational therapy
- Speech therapy
- Occupational therapy
- Vocational skills therapy
- Self care skill building.

Therapeutic passes (leave days) are an essential part of the treatment for client/families involved in ThGH. The therapeutic passes must be included as part of the treatment plan as they become appropriate. Documentation of the client's continued need for Therapeutic Group Home must follow overnight therapeutic passes. Reimbursement is available for up to 14 authorized therapeutic leave days during the course of the client’s Therapeutic Group Home stay.

**Service Expectations:**

- The Supervising Practitioner for the program must complete an Initial Diagnostic Interview prior to or within 24 hours. If the Supervising Practitioner of the ThGH program had completed an assessment with the youth prior to admission to the ThGH program and that assessment is still clinically relevant to the youth's condition, no additional assessment is needed.

- The Supervising Practitioner will also provide a face-to-face treatment intervention with the client at least every 14 calendar days after admission. The treatment plan will accordingly be updated each 14 days or more often as medically necessary.

- When aggressive and self injurious behaviors have been noted in the assessment, the initial and all subsequent treatment plan will include effective approaches for all staff to manage these behaviors.

- Within seven days of admission, the comprehensive treatment plan shall be developed by the established interdisciplinary team of staff providing services for each client. Each treatment team member shall sign and indicate their attendance and involvement in the treatment team meeting.

- Treatment interventions should be outcome focused based on the comprehensive assessment, treatment goals, culture, expectations and needs as identified by the youth and their family.

- The ThGH therapist will complete the CANS assessment within 10 days of admission, after each 90 days and again at discharge if at least 30 days have passed since the last CANS.

- Complete additional assessments and screenings as determined by the Supervising Practitioner. Assessment must take place as an ongoing activity throughout the treatment episode.
The progress notes shall contain a concise assessment of the client/family's progress and recommendations for revising the treatment plan, as indicated by the client/family's condition, and discharge planning.

Services provided to clients shall include communication and coordination with the family and/or legal guardian. Coordination with other services should occur as needed to achieve the treatment goals. All coordination services shall be documented in the client’s clinical record.

The provider must coordinate discharge planning with the Magellan Care Manager.

Adjunctive therapies such as life skills, community support building, leisure skill building, time management, pre-vocational skill building and health education (e.g., nutrition, hygiene, medications, personal wellness, etc.) may also be a part of the treatment program.

Family interventions must relate to the youth’s treatment plan and includes skill building regarding mental health and substance use disorder symptom management. This may include: de-escalation techniques, behavioral management techniques, coping skills, assisting the youth with social and life skills development, child development, medication compliance and relapse prevention.

Provide consultation and/or referral for general medical, psychiatric, psychological, vocational, educational services and psychopharmacology needs.

It is the provider’s responsibility to coordinate with other treating professionals for discharge referrals.

Discharge planning starts at admission and must be included in the treatment plan and all treatment plan reviews.

**Staffing:**
Staff, licensed to practice in the State of Nebraska, enrolled with Nebraska Medicaid, contracted and credentialed with Magellan and acting within their scope may provide this service and include:

- Licensed Mental Health Practitioner (LMHP)
- Provisionally Licensed Mental Health Practitioner (PLMHP)
- Licensed Independent Mental Health Practitioner (LIMHP)
- Licensed Psychologist
- Provisionally Licensed Psychologist
- Psychiatrist
- Advanced Practice Registered Nurse (APRN)
- Licensed Recreational Therapist
- Licensed Alcohol and Drug Counselor (LADC)
- Provisionally Licensed Alcohol and Drug Counselor (PLADC)
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- Non-licensed Direct Care Staff (provide psycho-educational and rehabilitative services only).

Staffing Requirements:
- All staff must demonstrate skill and competency in the treatment of clients with mental health and substance use disorders prior to the delivery of services.
- All staff must pass background checks with child abuse, sex offender, adult abuse and motor vehicle registers prior to employment.
- At least one staff per shift is required to have a current CPR and First Aid certification.

Supervising Practitioner: (Psychiatrist or clinical psychologist)
The Supervising Practitioner’s responsibilities include, but are not limited to:

- Complete an Initial Diagnostic Interview at =or within 24 hours of admission and prior to service delivery (EXCEPTION: When the ThGH Supervising Practitioner is the same psychiatrist or psychologist as the psychiatrist or psychologist who completed pre-admission assessment, it shall serve as the admission assessment provided that:
  - The assessment was completed within 30 days prior to admission;
  - The information in the assessment is current and provides sufficient recommendations for the ThGH team to develop an initial treatment plan)
- Assuming accountability to direct the care of the client at the time of admission and during the entire ThGH stay
- Assisting in developing and supervising a comprehensive treatment plan in the 10 days following admission, and monitor and supervise the treatment services delivered
- Providing a review and continued supervision of the treatment plan by updating the plan at a minimum of every 14 days thereafter
- Providing clinical direction in the development of the treatment and recovery plan
- Providing a face-to-face assessment/service to the client at least every 14-days or more often as medically necessary
- Providing crisis management including supervision and direction to the staff to resolve any crisis of the client’s condition; Monitoring and supervising an aggressive plan to transition the client from the program into less intensive treatment services as medically necessary
- Directly participate in and supervise the development of the comprehensive treatment plan within 10 days of admission (The recommendations of the Supervising physician serves as the treatment plan until the comprehensive treatment plan is developed by the 10th day following admission.)
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- Review and supervise discharge planning with each treatment plan review and provide direction for adjustment as necessary
- Provide supervision and direction for crisis situations.

Program/Clinical Director: (LMHP, Psychiatric RN, APRN, LIMHP, Licensed Psychologist. Dual Licensure [e.g., LMHP/LADC or LMHP/PLADC] is required for Dual ThGH programs)

The Director is a clinician fully licensed by the State of Nebraska, who is providing services within his/her scope of practice and licensure, and has two years of professional experience in the psychiatric treatment of children and adolescents.

The responsibilities of a program/clinical director include, but are not limited to:
- Overseeing, implementing and coordinating treatment services
- Continually incorporating new clinical information and best practices into the program to assure program effectiveness and viability
- Overseeing the process to identify, respond to and report crisis situations 24 hours a day, seven days a week
- Clinical management for the program in conjunction with and consultation with the Supervising Practitioner
- Assuring confidentiality and quality organization and management of clinical records and other program documentation
- Applying and supervising the gathering of outcome data and determining the effectiveness of the program.

Therapist/licensed clinician: (LMHP, LIMHP, PLMHP, LADC, PLADC, Licensed Psychologist, Provisionally Licensed Psychologist, APRN, Licensed Psychiatrist). The clinician(s) providing services for youth in the treatment program must be operating within their scope of practice and meeting program requirements.

The role and the responsibilities of the ThGH therapist include but are not limited to:
- Reporting to the program/clinical director and Supervising Practitioner for clinical and non-clinical guidance and direction
- Communicating treatment issues to the Program/Clinical Director and to the Supervising Practitioner as needed
- Providing individual, group, family psychotherapy and/or substance use disorder counseling
- Assisting in developing/updating treatment plans for clients in ThGH care in conjunction with the other interdisciplinary team members
- Providing assistance to direct care staff implementing the treatment plan when directed by the Program/Clinical Director
• Providing clinical information to the interdisciplinary team and attends treatment team meetings
• Providing continuous and ongoing assessment to assure clinical needs of clients and parent(s)/caregiver are met.

Registered Nurse or Advanced Practicing Registered Nurse (RN or APRN): Nursing services shall be provided by a Registered Nurse or APRN licensed by the State in which she or he practices. The nurse shall operate within his or her scope of practice and shall have documented experience and training in the treatment of children and adolescents. The responsibilities of a licensed Registered Nurse or a licensed APRN in the program include, but are not limited to:

• Reports to the program/clinical director for programmatic guidance
• Relates to the physician with a specialty in psychiatry and the medical physician as necessary regarding medical, psychiatric and physical treatment issues
• Provides nursing assessments on the first day of admission for each client
• Reviews all medical treatment orders and implements orders as directed
• Serves as a member of the interdisciplinary treatment team
• Provides medical intervention within his or her scope of practice and the registered nurse’s scope of practice as necessary
• Manages the storage, delivery and dispensing of medication to clients as necessary
• Oversees medication, education and health education issues
• Abides by all state and federal regulations
• Coordinates psychiatric and medical care per physician’s direction.

Direct Care/Behavioral Technician:

The direct care staff shall meet one of the following requirements:

(1) A bachelor’s degree or higher in psychology, sociology or related human service field, plus a minimum of one year work experience or graduate studies in direct child/adolescent services or mental health and/or substance use disorder services

(2) Two years of post-high school education in the human services field, plus a minimum of two years of experience or training in the human services field with demonstrated skills and competencies in treatment of youth with mental illness.

Direct Care Staff shall:

• Successfully complete the initial program training and the program’s competency check
Clearly understand the treatment plan and discharge plan; demonstrate skill and competency in the treatment of clients with mental health and/or substance use disorders prior to the delivery of service

Understand the program philosophy

Understand de-escalation techniques and demonstrate the ability to implement those techniques effectively

Shall pass the child abuse check, adult abuse registry and motor vehicle screens

Complete specific training for behavioral management and update the training as required by the program

Understand de-escalation techniques and demonstrate the ability to implement those techniques effectively.

Direct Care Staff perform the following functions:

Provide psycho-educational activities and interventions to support clients in developing social, recreational and other independent living skills as appropriate

Provide continual supervision to clients in the program

Maintain awareness of safety issues and provide safety intervention within the milieu

Report all crisis or emergency situations to the program/clinical director or to the program/clinical director’s designee in the absence of the program/clinical director.

Staff Ratios:

All staffing must be adequate to meet the individualized treatment needs of the client and meet the responsibilities of each staff position as outlined in the Staffing Requirements section to include:

All staffing shall be adequate to meet the individualized treatment needs of the client and meet the responsibilities of each staff position as outlined in the staffing requirements.

The Supervising Practitioner’s hours shall be adequate to provide the necessary direct services and the administrative responsibilities as the supervisor of the day treatment program and the individualized care for each of the clients.

The Program Director shall have adequate hours to fulfill the expectations and responsibilities of the program/clinical director’s description in this document

Registered Nurse hours shall be adequate to provide the necessary nursing services to all clients admitted to the program and to meet all health care needs of the client during the client’s day treatment service episode.

The minimum ratio of therapists/licensed practitioners to clients served shall be at least 1:12.
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- Direct Care Staff minimums at least 1:4 with a minimum of two staff on duty per day-time shift for an eight bed capacity. This ratio may need to be increased if treatment interventions are delivered outside of the physical location of the program or due to a level of acuity of the youth.
- ThGH Treatment Team consists of the client’s family and/or legal guardian, the supervising physician, a licensed mental health professional, the RN and Direct Care Staff.

The following charges can be reimbursed separately from the Therapeutic Group Home fee when the services are medically necessary, part of the client’s overall treatment plan and are in compliance with other state and federal regulations:

- Direct client services provided by the Supervising Practitioner
- Prescription drugs including injectible medications
- Direct client services performed by a physician other than the physician directing the program
- All laboratory or physical health diagnostic procedures prescribed by a physician
- Direct services of a licensed physician whose specialty is psychiatry
- Treatment services for physical injury or illness provided by non-mental health practitioners operating within their scope of practice
- Licensed practitioners who provide mental health and/or substance use disorder services are reimbursed separately provided they are identified on the Therapeutic Group Home provider agreement and the services of the practitioner are billed by the agency. Direct services by a licensed practitioner for treatment services are billed separately.

Psychiatric Residential Treatment Facility (PRTF) for Children/Adolescents

Purpose and Definition:
PRTF treatment provides 24-hour services for children/adolescents who have demonstrated severe and persistent psychiatric disorders and/or substance use disorders. Children/adolescents receive therapeutic intervention and specialized programming in a controlled environment with a high degree of supervision and structure. The program addresses the identified problems through a wide range of diagnostic and treatment services as well as through training in basic skills such as social skills and activities of daily living in the context of a comprehensive, interdisciplinary treatment plan.

PRTFs incorporate a trauma informed philosophy in treatment services and adapt a recovery-based philosophy. Providers of PRTF adhere to a philosophy which believes that individuals can and do recover from their mental health and/or substance use disorder symptoms and problems and can lead full and productive
lives. PRTF providers make every effort to encourage meaningful reintegration of a client into the community to diminish the use of other more restrictive treatment modalities. PRTF providers are trauma informed, as such they:

1. Understand and are sensitive to the effects of psychological trauma
2. Understand the needs of trauma survivors
3. Screen for trauma symptoms and past history of traumatic events
4. Provide trauma-sensitive services and recognize that traumatization can occur when safe, effective and responsive services are not available

Psychiatric residential treatment facility services shall be family-centered, culturally competent and developmentally appropriate.

PRTF services shall be provided under the direction of a licensed physician with a specialty in psychiatry that is enrolled as a provider of Nebraska Medicaid.

Licensing/Accreditation:

- Providers of this service must be appropriately enrolled with Nebraska Medicaid
- Providers must be credentialed and contracted with Magellan Behavioral Health of Nebraska, Inc. as outlined in the Handbook Supplement
- Providers must maintain licensure as directed by the Nebraska Department of Health and Human Services. Providers will notify Magellan of all changes to licensure and submit copies of all current/active licenses to Magellan
- Organizations providing this service must be licensed, certified, or accredited through a national accreditation body such as The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF) or by the Council on Accreditation (COA). Providers will provide Magellan copies of all current/active accreditation certificates and the most recent accreditation site review report.

Features/Hours:

Providers of PRTF services shall provide 40 hours of psychotherapy and other treatment interventions per week. The following services and frequency of services must be available to the individual unless clinically contraindicated:

1. Twice weekly individual psychotherapy and/or substance use disorder counseling;
2. Minimum three times a week group psychotherapy and/or substance use disorder counseling;
3. Weekly family psychotherapy and/or family substance use disorder counseling. A family therapy session is provided on the day of admission and the day prior to discharge;
4. Occupational therapy;
5. Physical therapy;
6. Speech therapy;
7. Laboratory services;
8. Transportation; and
9. Medical Services, as necessary; and
10. Nursing service availability seven days a week, 365 days a year by an onsite nurse during awake hours and by an on-call availability during sleep hours.
11. Psycho-educational services must be available from the PRTF and must be modified to meet the unique treatment needs of the individual as described in the individual's Plan of Care:
   • Crisis intervention and aftercare planning;
   • Life survival skills;
   • Social skills building;
   • Substance use disorder prevention interventions;
   • Self-care services;
   • Medication education, compliance and information regarding the effectiveness of medication;
   • Health care issues which may include nutrition, hygiene and personal wellness;
   • Vocational/career planning; and
   • Recreational activity (recreational activity is not considered in 40 hours per week of therapy but healthful outcomes of recreation and exercise may be a part of a psycho-educational group service).

The program must have formal arrangement for access to:
   • Psychological services
   • Pharmacy services
   • Dietary services.
   • Laboratory services.
   • Physical therapy;
   • Transportation; and
   • Medical Services, as necessary; and

The following optional services may also be provided:
   • Recreational therapy
   • Speech therapy
   • Occupational therapy
   • Vocational skills therapy
   • Self-care skill building

Therapeutic passes (leave days) are an essential part of the treatment for client/families involved in PRTF. The therapeutic passes must be included as part of the treatment plan as they become appropriate. Documentation of the client's continued need for PRTF must follow overnight therapeutic passes. Reimbursement
is available for up to 14 authorized therapeutic leave days during the course of the client's PRTF stay.

**Service Expectations:**
- Complete additional assessments and screenings as determined by the physician and treatment team. Assessment must take place as an ongoing activity throughout the entire length of stay.
- The interdisciplinary team consists of the youth, family, guardian, therapist/licensed clinician, supervising physician, physician, psychologist, social worker, RN, occupational therapist and other supportive individuals identified by the supervising physician’s recommendations and family preferences.
- The interdisciplinary team develops and signs a family centered, outcome focused comprehensive plan of care within 14 calendar days of admission and updates the treatment plan as frequently as medically indicated but at least every 30 days. Each updated version of the plan of care must be reviewed, approved and signed by each member of the treatment team including the Supervising Practitioner.
- The plan of care means a written plan developed for each individual to improve his/her condition to the extent that inpatient care is no longer necessary. The plan of care must:
  - Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the individual’s situation and reflects the need for inpatient psychiatric care;
  - Be developed by a team of professionals specified in 32-008.07 in consultation with the individual and the parents, legal guardian or others in whose care the individual will be released after discharge;
  - State treatment objectives;
  - Prescribe an integrated program of therapies, activities and experiences designed to meet the objectives; and
  - Include post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the individual’s family, school and community upon discharge. The discharge plan must:
    - Identify the custodial parent or custodial caregiver anticipated at discharge;
    - Identify the school the patient will attend;
    - Include individualized educational program (IEP) recommendations as necessary;
    - Outline the aftercare treatment plan; and
    - List barriers to community reintegration and progress toward resolving these barriers since the last review. Include the needs of the custodial parent or custodial caregiver.
• Treatment interventions must be outcome focused based on the comprehensive assessment, treatment goals, culture, expectations and needs as identified by the youth and their family.
• Family interventions must relate to the youth’s treatment plan and include skill building regarding mental health and substance use disorder symptom management. This may include: de-escalation techniques, behavioral management techniques, coping skills, social and life skills development, child development, medication compliance and relapse prevention.
• Adjunctive therapies such as life skills, community support building, leisure skill building, time management, pre-vocational skill building and health education (e.g., nutrition, hygiene, medications, personal wellness, etc.) may also be a part of the treatment program.
• Medication education including medication management will be provided by the appropriate staff person within the PRTF to youth/family/guardian regarding expected benefits, potential side effects, potential interactions, dosage, obtaining/filling prescriptions, etc.
• Mandatory treatment services include: ongoing assessment, individual, group and family psychotherapy or substance use disorder counseling service, and psycho-educational services.
• One family session the day of admission and one family session on the day prior to discharge are required. Family therapy is also required one time per week on an on-going basis.
• The PRTF therapist will complete the CANS assessment within 10 days of admission, after each 90 days and again at discharge if at least 30 days have passed since the last CANS.
• Provide awareness and skill development for youth and/or family/guardian in regards to accessing community resources and natural supports that could be used to help facilitate youth function and tenure in the community.
• All physical/medical, dental, vision, dental and mental health and substance use disorder needs must be identified and met by the treatment plan. The care must be provided by the PRTF facility.
• Discharge planning starts at admission and must be included in the treatment plan and all treatment plan reviews. Prior to discharge the PRTF staff must facilitate, confirm, and document that contacts are made with the identified community service or treatment provider as identified in the discharge plan.

**Staffing:**
Staff, licensed to practice in the State of Nebraska, enrolled with Nebraska Medicaid, contracted and credentialed with Magellan and acting within their scope may provide this service and include:
- Licensed Mental Health Practitioner (LMHP)
- Provisionally Licensed Mental Health Practitioner (PLMHP)
- Licensed Independent Mental Health Practitioner (LIMHP)
- Licensed Psychologist
• Provisionally Licensed Psychologist
• Psychiatrist
• Advanced Practice Registered Nurse (APRN)
• Licensed Recreational Therapist
• Licensed Alcohol and Drug Counselor (LADC)
• Provisionally Licensed Alcohol and Drug Counselor (PLADC)
• Non-licensed Direct Care Staff (provide psycho-educational and rehabilitative services only).

Staffing Requirements:
All staff must demonstrate skill and competency in the treatment of clients with mental health and substance use disorders prior to the delivery of services.

All staff must pass background checks with child abuse, sex offender, adult abuse and motor vehicle registers. All staff must understand and demonstrate competency in the use of restraints and seclusion per CFR 42.

**Supervising Physician:** (Psychiatrist)
The responsibilities of the supervising physician include but are not limited to the following:

• There are three specific Certifications of Need (CON) requirements that are attested to by the physician referring the client for PRTF and at admission by the Supervising Physician in the PRTF, as per the CFR:
  1. Ambulatory care resources available in the community do not meet the treatment needs of the recipient
  2. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician, and
  3. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

• Complete an Initial Diagnostic Interview prior to delivering treatment services and within 24 hours of admission. If the physician who made the referral is the same physician of the PRTF program, then the referral assessment can serve as the admission diagnostic interview if the assessment provides clear direction to the PRTF program regarding recommendations to develop the treatment plan and was completed within the previous 30 days.

• Provide a face-to-face treatment service every 14 days at minimum, every seven days is the preference.

• Directly participate in and supervise the development of the comprehensive treatment plan within 14 days of admission. (The recommendations of the Supervising physician serve as the treatment plan until the comprehensive treatment plan is developed by the 14th day following admission).
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- Update the goal-directed treatment plan with the treatment team each 30 days at minimum, every seven days is the preference.
- Monitor and supervise the treatment services delivered.
- Review and supervise discharge planning with each treatment plan review and provide direction for adjustment as necessary.
- Provide supervision and direction for crisis situations.
- Provide continuous and ongoing assessment to assure the clinical needs of the youth and family are met. This includes transitioning of youth to other treatment and care settings, or other types of supports as necessary.

Program/Clinical Director: (LMHP, Psychiatric RN, APRN, LIMHP, Licensed Psychologist, or licensed physician with a specialty in psychiatry. Dual Licensure, e.g., LMHP/LADC or LMHP/PLADC, is required for Dual PRTF programs.)

The Director is a clinician fully licensed by the State of Nebraska, providing services within his or her scope of practice and licensure, and has two years of professional experience in a treatment setting similar to a PRTF. The Program / Clinical Director cannot also serve in the role of the program’s therapist.

The responsibilities of the Program/Clinical Director include but are not limited to the following:
- Oversees, implements and coordinates all treatment services and activities provided within the program under the direction of the Supervising Practitioner
- Continually incorporates new clinical information and best practices into the program to assure program effectiveness and viability
- Oversees the process to identify, respond to and report crisis situations 24 hours a day, seven days a week
- Is responsible, in conjunction with the supervising physician for the program’s clinical management
- Assures quality, organization, confidentiality and management of clinical records and other program documentation
- Oversees the gathering of outcome data and determine the effectiveness of the program for the clients served
- Supervises all procedures and training regarding behavior management in the PRTF milieu, particularly regarding de-escalation techniques and the use of timeout, and orders for the use of restraint or seclusion (42 CFR § 483.358).

Therapist/licensed clinician: (LMHP, LIMHP, PLMHP, LADC, Licensed Psychologist, Provisionally Licensed Psychologist, APRN, Licensed Psychiatrist). The clinician(s) providing services for youth in the treatment program must be operating within their scope of practice and meeting program requirements.
The role and responsibilities of the therapist include but are not limited to the following:

- Implements the comprehensive treatment plan components by providing individual, group and family therapy and/or substance use disorder counseling
- Reports to the Program/Clinical Director for clinical and non-clinical guidance and direction
- Assists with developing and updating treatment plans for individuals, in conjunction with the interdisciplinary team
- Provides input to the treatment team and attends treatment team meetings
- Provides continuous and ongoing assessment in conjunction with the supervising physician and the treatment team to assure the clinical needs of the youth and family are met. This includes transitioning of youth to other treatment and care settings, or other types of supports as necessary.

Registered Nurse or Advanced Practicing Registered Nurse (RN or APRN): Nursing services shall be provided by a Registered Nurse or APRN licensed by the State in which she/he practices. The nurse shall operate within his/her scope of practice and shall have documented experience and training in the treatment of children and adolescents. The PRTF shall maintain 24-hour nursing coverage by a registered nurse seven days per week, 365 days per year. The role and responsibilities of the licensed Registered Nurse or licensed APRN includes but is not limited to the following:

- Provide nursing assessments on the first day of admission for each client
- Report to the program/clinical director for programmatic guidance
- Consult with psychiatrist and the medical physician, as necessary, regarding medical, psychiatric and physical treatment issues that may arise for patients
- Receive and review all medical treatment orders and implement orders as directed
- Provide medical intervention within his or her scope of practice as necessary
- Manage the storage and dispensing of medication to clients as necessary
- Oversee and provide medication education and support to improve patient adherence to prescribed medical and physical health regimens
- Coordinate psychiatric and medical care per a physician’s direction
- Comply with the responsibilities for the role of a registered nurse in the seclusion and restraint regulations identified for PRTF’s by the Centers for Medicaid and Medicare (42 CFR § 483.358)
- Serve as a member of the interdisciplinary treatment team and participate in treatment team meetings.

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

Direct Care Staff shall:
- Successfully complete the initial program training and the program’s competency check
- Clearly understand the treatment plan and discharge plan; demonstrate skill and competency in the treatment of clients with mental health and/or substance use disorders prior to the delivery of service
- Understand the program philosophy
- Understand de-escalation techniques and demonstrate the ability to implement those techniques effectively
- Understand and demonstrate competence in the use of restraint and seclusion as per (42 CFR § 483.358)
- Shall pass the child abuse check, adult abuse registry and motor vehicle screens
- Complete specific training for behavioral management and update the training as required by the program.

Direct Care Staff perform the following functions:
- Provide psycho-educational activities and interventions to support clients in developing social, recreational and other independent living skills as appropriate
- Provide continual supervision to clients in the program
- Maintain awareness of safety issues and provide safety intervention within the milieu
- Report all crisis or emergency situations to the program/clinical director or to the program/clinical director’s designee in the absence of the program/clinical director.

Staff Ratios:
All staffing must be adequate to meet the individualized treatment needs of the client and meet the responsibilities of each staff position as outlined in the Staffing Requirements section to include:

1. All staffing shall be adequate to meet the individualized treatment needs of the client and meet the responsibilities of each staff position as outlined in the staffing requirements.
2. The Supervising Practitioner’s hours shall be adequate to provide the necessary direct services and the administrative responsibilities as the supervisor of the day treatment program and the individualized care for each of the clients.
3. The program director shall have adequate hours to fulfill the expectations and responsibilities of the program/clinical director’s description in this document.

4. Registered Nurse hours shall be adequate to provide the necessary nursing services to all clients admitted to the program and to meet all health care needs of the client during the client’s day treatment service episode.

5. The minimum ratio of therapists/licensed practitioners to clients served is at least 1:10.

6. Direct Care Staff minimums: 1:4 during waking hours and 1:6 overnight.

7. PRTF Treatment Team consists of the client’s family and/or legal guardian, the Supervising Physician, a licensed mental health professional, the RN and Direct Care Staff.

**23-Hour Crisis Observation**

**Purpose and Definition:**
This level of care provides up to 23:59 hours of care in a secure and protected environment. The program is medically staffed, psychiatrically supervised and includes continuous nursing services. The primary objective of this level of care is for prompt evaluation and/or stabilization of individuals presenting with acute symptoms or distress. Before or at admission, a comprehensive assessment is conducted and a treatment plan developed. The treatment plan should place emphasis on crisis intervention services necessary to stabilize and restore the individual to a level of functioning that does not require hospitalization.

This level of care may also be used for a comprehensive assessment and to obtain clarification regarding previously incomplete diagnostic information that may lead to a determination that the individual requires a more intensive level of care.

This service is not appropriate for individuals who by history or initial clinical presentation require services of an acute care setting exceeding 23:59 hours. Duration of services at this level of care may not exceed 23:59 hours, by which time stabilization and/or a determination of the appropriate level of care will be made, and facilitation of appropriate treatment and support linkages will be coordinated by the treatment team.

**Licensing/Accreditation:**
- Providers of this service must be appropriately enrolled with Nebraska Medicaid
- Providers must be credentialed and contracted with Magellan Behavioral Health of Nebraska, Inc. as outlined in the Handbook Supplement
• Providers must maintain licensure as directed by the Nebraska Department of Health and Human Services. Providers will notify Magellan of all changes to licensure and submit copies of all current/active licenses to Magellan.

• Organizations providing this service must be licensed, certified, or accredited through a national accreditation body such as The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF) or by the Council on Accreditation (COA). Providers will provide Magellan copies of all current/active accreditation certificates and the most recent accreditation site review report.

Features/Hours:
The program is available 24 hours a day, seven days a week.
Services typically include:
• Assessment
• Nursing services
• Medication evaluation/management
• Psychiatric assessment
• Psychological assessment
• Individual therapy
• Group therapy.

Service Expectations:
• The Supervising Practitioner (psychiatrist) must meet with the member face-to-face within 12 hours of admission.
• The provider must coordinate discharge planning with a Magellan Care Manager.
• Appropriate after care instructions and follow up referrals are completed at discharge.

Staffing:
Staff will include:
• Supervising Practitioner (Psychiatrist)
• Nursing services (24 hours per day)
• Therapists (PLMHP, LMHP, LIMHP or RN with a master's degree in psychiatric nursing, counseling or related mental health field)
• Para-professionals (Bachelor's degree in human services).

Staffing Ratios:
• The minimum therapist to member ratio is 1:10.
• The minimum direct care staff to member ratio is 1:4 during waking hours and 1:6 during non-awake hours.
• 75% of paraprofessional staff must have a bachelor's degree or five years of experience in the human services field.
Partial Hospitalization

Purpose and Definition:
Partial hospitalization is a hospital-based treatment program that provides diagnostic and treatment services on a level of intensity similar to an inpatient program, but on less than a 24-hour basis. These services include therapeutic milieu, nursing, psychiatric evaluation, medication management, group, individual and family therapy. The environment at this level of treatment is highly structured, and there should be a staff-to-patient ratio sufficient to ensure necessary therapeutic services, professional monitoring, control, and protection. Partial hospital treatment may be appropriate when a member does not require the more restrictive and intensive environment of a 24-hour inpatient or residential setting, but does need up to eight hours of clinical services each day. Partial hospitalization can be used both as a transitional level of care (e.g., step-down from inpatient or residential treatment) as well as a stand-alone level of care to stabilize a deteriorating condition and avert hospitalization or residential treatment. This level of care is not appropriate for youth receiving treatment in a PRTF, ThGH or PRFC.

Policy:
Mental health partial hospitalization services are available to youth and adult members. Substance use disorder partial hospitalization services are available to members age 18 and younger.

Licensing/Accreditation:
- Providers of this service must be appropriately enrolled with Nebraska Medicaid
- Providers must be credentialed and contracted with Magellan Behavioral Health of Nebraska, Inc. as outlined in the Handbook Supplement
- Providers must maintain licensure as directed by the Nebraska Department of Health and Human Services. Providers will notify Magellan of all changes to licensure and submit copies of all current/active licenses to Magellan
- Organizations providing this service must be licensed, certified, or accredited through a national accreditation body such as The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF) or by the Council on Accreditation (COA). Providers will provide Magellan copies of all current/active accreditation certificates and the most recent accreditation site review report.
Appendix B
Magellan Behavioral Health of Nebraska, Inc. December 2015
Mental Health and Substance Use Disorder Treatment Services for Children and Adolescents (Ages 20 and Younger

Features/Hours:
A structured therapeutic milieu with a minimum of six hours per day of treatment services (full day) or three hours of treatment services/day (half day) a minimum of five days per week.

Minimum services:
- Individual therapy (minimum of two times per week)
- Group (daily)
- Family therapy (minimum of one per week)
- Recreation therapy (daily)
- Psycho-educational groups (daily).

The frequency of attendance may change based on an individual member's needs. Length of stay is variable depending on presenting symptoms and diagnosis. The typical length of stay is one to four weeks. School, if provided, needs to meet education requirements of a Level 3 program. School hours are not included in the minimum required treatment hours, as education is not a covered service with Magellan.

Service Expectations:
- Psychiatric diagnostic evaluation by the attending psychiatrist within 24 hours of admission
- Nursing assessment by a licensed registered nurse within 24 hours of admission
- Substance use disorder assessment when appropriate
- Laboratory, radiological, and other diagnostic tests as necessary
- A physical examination, including a complete neurological examination when indicated, within 24 hours of admission by a licensed physician.

The treatment plan will:
- Document involvement of the member and his or her family, in its development
- Be completed within 24 hours
- Be reviewed, updated and endorsed by the treatment team at once per week
- Discharge planning begins at the time of admission and includes:
  - Next appropriate level of care
  - Scheduled follow up appointments
  - Community based support services.

Programming at this level of care includes:
- Individual therapy
- Group therapy
- Family therapy
• Education for diagnosis, treatment, relapse prevention, life skills
• A psychiatrist or an APRN will provide a face-to-face service at least four out of every five days of treatment.

The program will have access to dietary, pastoral, emergency medical, recreational therapy, psychological, laboratory and other diagnostic services. When the inpatient is a child, adolescent or an adult with a guardian, the identified family must be involved in the assessment, treatment and discharge planning. Initial contact with the family must occur within the first 72 hours.

**Staffing:**
Staff will include:
• Licensed Mental Health Practitioner (LMHP)
• Provisionally Licensed Mental Health Practitioner (PLMHP)
• Licensed Independent Mental Health Practitioner (LIMHP)
• Licensed Psychologist
• Provisionally Licensed Psychologist
• Psychiatrist
• Advanced Practice Registered Nurse (APRN)
• Licensed Recreational Therapist
• Licensed Alcohol and Drug Counselor (LADC).

The minimum program staff to member ratio is 1:3. The minimum therapist to member ratio is 1:8.

Advance Practice Registered Nurses (APRN) may provide medical services and treatment in a partial hospital psychiatric program when practicing within their scope and specialty, and when the psychiatrist has identified their roles and responsibilities. APRN functions may not replace required physician involvement in treatment.

**Acute Inpatient**

**Purpose and Definition:**
Acute inpatient treatment represents the most intensive level of care. Interdisciplinary assessments and multi-modal interventions are provided in a 24 hour secure and protected setting which is a medically staffed and psychiatrically supervised treatment environment. Twenty-four hour skilled nursing care, daily medical care and a structured treatment milieu are required. The goal of acute inpatient care is to stabilize acute psychiatric and substance use disorder conditions.
Licensing/Accreditation:
- Providers of this service must be appropriately enrolled with Nebraska Medicaid
- Providers must be credentialed and contracted with Magellan Behavioral Health of Nebraska, Inc. as outlined in the Handbook Supplement
- Providers must maintain licensure as directed by the Nebraska Department of Health and Human Services. Providers will notify Magellan of all changes to licensure and submit copies of all current/active licenses to Magellan
- Organizations providing this service must be licensed, certified, or accredited through a national accreditation body such as The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF) or by the Council on Accreditation (COA). Providers will provide Magellan copies of all current/active accreditation certificates and the most recent accreditation site review report.

Features/Hours:
Typical acute inpatient services for adults range from one to five days. Typical acute inpatient services for youth range from one to 10 days. Emergency Protective Custody services are available for up to seven days. The program provides skilled nursing coverage 24 hours a day, seven days a week. The program has the ability to accept admissions at any time.

Service Expectations:
The treatment plan will:
- Document involvement of the member and his/her family, in its development
- Be completed within 24 hours
- Be reviewed, updated and endorsed by the treatment team at least every 48 hours.

Discharge planning begins at the time of admission and includes:
- Next appropriate level of care
- Scheduled follow up appointments
- Community based support services.

Programming at this level of care includes:
- Individual therapy
- Group therapy
- Family therapy
- Education for diagnosis, treatment, relapse prevention, life skills

The program will have access to dietary, pastoral, emergency medical, recreational therapy, psychological, laboratory and other diagnostic services. When the inpatient is a child, adolescent or an adult with a guardian, the identified family must be involved in the assessment, treatment and discharge planning. Initial contact with the family must occur within the first 72 hours.
Staffing:
Staff will include:

- Supervising Practitioner (Psychiatrist)
- Program Director (RN with a master’s degree in psychiatric nursing, counseling or related mental health field or LMHP)
- 24-hour nursing staff (at least 1 RN per shift)
- Non-licensed staff supervised by the program manager
- Social work staff.

The minimum program staff to member ratio is 1:3. The minimum therapist to member ratio is 1:8.

Supervising Practitioner Involvement:
In addition to the responsibilities outlined in the standards common to all levels of care, the Supervising Practitioner will:

- Meet with the member face-to-face within 24 hours of admission
- Provide face-to-face service to the member at least six out of every seven days
- Be physically present at Treatment Team meetings.

Advance Practice Registered Nurses (APRN) may provide medical services and treatment in hospital psychiatric programs when practicing within their scope and specialty, when the psychiatrist has identified their roles and responsibilities. APRN functions may not replace required physician involvement in treatment.