Revision Details to Section 2.0 Overview of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

January 2021

Added language that applies across services pertaining to provider's responsibilities.
Publication date: 1/5/21

All mental health services must be medically necessary in accordance with LAC 50:I.1101. The medical necessity for services shall be determined by a licensed mental health professional (LMHP) or physician who is acting within the scope of their professional license and applicable state law. There shall be member involvement throughout the planning and delivery of services.

Services shall be:

- Delivered in a culturally and linguistically competent manner;
- Respectful of the individual receiving services;
- Appropriate to individuals of diverse racial, ethnic, religious, sexual and gender identities and other cultural and linguistic groups; and
- Appropriate for age, development; and education.

March 2020

Added language to clarify LDH's and provider's responsibilities regarding the manual.
Publication date: 3/30/20

The Louisiana Department of Health (LDH) strives to make the information in this manual chapter as accurate, complete, reliable and as timely as possible. This manual chapter is subject to change as the implementation and operations of specialized behavioral health services continue to evolve. Providers are responsible for ensuring services are delivered in accordance with this manual and compliant with any authorities in effect on the date of service. Prior to inclusion of behavioral health services in this Medicaid Service Provider Manual in 2017, the Service Definition Manual version 9 (SDM v9) was in effect. Providers must ensure services are delivered in accordance with the Medicaid Service Provider Manual and any other authorities in effect on the date of service.

LDH, its employees, agents, or others will not be liable or responsible for any claim, loss, injury, liability, or damages related to your use of, or reliance upon this information.

This information is not intended to be a substitute for professional legal, financial or business advice. This manual does not create, nor is it intended to create, an attorney-client relationship between you and LDH. You are urged to consult with your attorney, accountant or other qualified professional if you require advice or opinions tailored to your specific needs and circumstances.

Revision Details to Section 2.1 Provider Requirements of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

June 2018

Revision made to page add note relevant to specialized behavioral health providers and the Healthy Louisiana Medicaid Managed Care Program/Coordinated System of Care (CSoC) Contractor. Clarified that not all behavioral health providers are enrolled with Medicaid.
Publication date: 6/29/18

PROVIDER REQUIREMENTS

~~A provider must be enrolled in the Medicaid Program and meet the provider qualifications at the time service is rendered to be eligible to receive reimbursement through the Louisiana Medicaid Program.~~

All providers must meet the provider qualifications at the time service is rendered to be eligible to receive reimbursement directly from Medicaid or from a Medicaid managed care contractor. Providers must also be enrolled in Medicaid in order to be reimbursed when rendering and billing for services to recipients in Medicaid's Fee for Service program (non-Managed Care), or to Medicaid recipients that are dually enrolled in Medicare and are receiving Medicare eligible services. For more information regarding billing for specialized behavioral health services for dual eligible members, refer to LDH Information Bulletin 15-17 posted at http://ldh.la.gov/index.cfm/page/1198.

Revision Details to Section 2.2 Bed Based Services Crisis Stabilization for Adults Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

January 2023

Moved Crisis Stabilization for Youth section to Section 2.2 Bed Based Services in the manual.
Publication date: 8/3/22

August 2022

New chapter added to the manual.
Publication date: 8/3/22

Revision Details to Section 2.2 Bed Based Services Crisis Stabilization for Adults Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

February 2024

Revisions to update criteria.
Publication date: 2/05/24

Crisis Stabilization for Adults

Crisis Stabilization (CS) for adults is a short-term bed-based crisis treatment and support service for members who have received a lower level of crisis services and are at risk of hospitalization or institutionalization, including nursing home placement. CS is utilized when additional crisis supports are necessary to stabilize the crisis and ensure community tenure in instances in which more intensive inpatient psychiatric care is not warranted or when the member's needs are better met at this level. CS operates 24 hours a day, seven days a week as short-term mental health crisis response, offering a voluntary home-like alternative to more restrictive settings, such as the emergency departments, or coercive approaches, such as Physician Emergency Certificates (PECs), law enforcement holds, or Orders of Protective Custody (OPC). This voluntary service is designed to ameliorate a psychiatric crisis and/or reduce acute symptoms of mental illness and to provide crisis relief, resolution, and intensive supportive resources for adults who need intensive temporary ~~twenty-four (24) hours a day, seven (7) days a week~~ support and is not intended to be a housing placement.

Service Utilization

CS requires ~~prior authorization~~ concurrent review after the initial 24 hour period, is based on medical necessity, and is intended to assure ongoing access to medically necessary crisis response services and supports until the current crisis is resolved, or until the member can access alternative behavioral health supports and services. The CS provider must immediately notify the MCO of the member's admission. The member's treatment record must reflect relief, resolution and problem solving of the identified crisis or referral to an alternate provider. ~~Additional units may be approved with prior authorization~~.

NOTE: Such encounters will be subject to retrospective review. In this way, IF it is determined that the available/reviewed documentation does NOT support the crisis, the payment may be subject to recoupment.

Limitations/Exclusions
The per diem for CS and BHCC cannot be billed on the same day. Restraints and seclusion cannot be used in CS.

January 2023

Moved Crisis Stabilization for Youth section to Section 2.2 Bed Based Services in the manual.
Publication date: 8/3/22

August 2022

New chapter added to the manual.
Publication date: 8/3/22

Revision Details to Section 2.3 Outpatient Services – Adult Crisis Response Services of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

February 2024

Revisions made to update criteria.
Publication date: 2.05.24

Documentation
Consent needed for non-emergencies: Providers must obtain oral or written consent ~~in accordance with the Louisiana Medical Consent Law, La. R.S. § 1159.1 et seq~~, when an emergency does not exist or no longer exists. Written consent to treatment is preferred. For treatment of a minor (under the age 18 during a non-emergency, documentation of consent for treatment shall include consent from the minor, parent, or person with legal authority to act on the minor's behalf. ~~La. R.S. §§ 40:1079.1(A), 40:1159.4; see also La. R.S. 40:1157.1~~.

Behavioral Health Crisis Care (BHCC)
Service Utilization
NOTE: Such encounters will be subject to retrospective review. In this way, IF it is determined that the available/reviewed documentation does NOT support the crisis, the payment may be subject to recoupment.

Exclusions
BHCC is not to be utilized as step down services from other residential or inpatient psychiatric service settings or ~~Substance Use Disorder~~ SUD residential service settings.

The per diem for BHCC and CS cannot be billed on the same day. Restraints and seclusion cannot be used in a BHCC Center. BHCC cannot be billed for consecutive days.

Community Brief Crisis Support (CBCS)
Components
Providing follow up to the member and authorized member's caretaker and/or family within 24 hours as appropriate and desired by the member and up to 15 days following presentation to an emergency department for a reason related to emotional distress or initial contact with the CBCS provider once the previous crisisCI provider (MCR, BHCC, CS) provider has discharged the member to ensure continued stability post crisis for those not accessing higher levels of care, including but not limited to:

December 2023

Revisions made to update criteria throughout section.
Publication date: 12.14.23

CRISIS RESPONSE SERVICES ~~FOR ADULTS~~
For youth, crisis services additionally are not intended to substitute for already-approved and accessible home and community based interventions as included on the plan of care (POC) for youth enrolled in the Coordinated System of Care (CSoC) program.

The provisions contained in this chapter section apply to the following crisis response services for adults: 1. Mobile Crisis Response (MCR) (Effective 3/1/2022) (expansion to ages under 21 effective 04/01/2024);

The provisions contained in this ~~chapter~~ section apply to the following crisis response services ~~for adults~~:

1. Mobile Crisis Response (MCR) (Effective 3/1/2022) (expansion to ages under 21 effective 04/01/2024);
2. Behavioral Health Crisis Care (BHCC) (Effective 4/1/2022) for ages 21 and above; And
3. CBCS (Effective 3/1/2022) (expansion to ages under 21 effective 04/01/2024).

Interventions

1. Interventions are driven by the member and include resolution focused treatment, peer support, safety planning, service planning, and care coordination designed to de-escalate the crisis. Strategies are developed for the member to use post current crisis to mitigate risk of future incidents until the member (and caregiver, for youth-directed services) engages in alternative services, if appropriate. Interventions must be provided under the supervision of an LMHP or psychiatrist who is acting within the scope of his/her professional license and applicable state law; and~~.~~

b. For services delivered to minor youth, the interventions focus on the crisis experience of the youth and the experience of the parent or guardian whose youth is in crisis. Crisis services staff, with particular assistance from the recognized family peer support specialist (RFPSS), provide support to caregivers during interventions for their children. RFPSS team members work collaboratively with other crisis services team members to intervene and stabilize youth in crisis, with a focus on providing support to caregivers, helping caregivers actively engage in the crisis services intervention, and offering their own personal experience to help educate the next steps for the youth in crisis;~~.~~

3. Interventions include using person-~~-~~centered approaches, such as crisis resolution and debriefing with the member (and caregiver, when present for youth-directed services) experiencing the crisis for relief, resolution and problem solving of the crisis;

Care Coordination

1. All levels of crisis providers shall coordinate care for the member following the crisis event as needed. Care coordination includes the following activities:
   a. Coordinating the transfer to alternate levels of care within 24 hours when warranted, including but not limited to:
      iv. CBCS - when the member requires ongoing support at home or in the community subsequent to an initial crisis;
      v. Crisis stabilization (CS) – when the member may need additional time outside of the home without being at immediate risk for inpatient treatment due to experiencing severe intoxication or withdrawal episodes that cannot be managed safely in this setting, immediate suicide risk, or currently violent;
3. Coordinating contact through a warm handoff with the member's existing or new behavioral health provider. For youth this may include warm handoff with the member's wraparound agency if the youth is enrolled or has been referred to CSoC; and

Service Delivery

4. Appropriate for the individual's age, development, and education.

Soft Launch

1. Hours and days of operation;
   NOTE: Providers are expected to maintain established hours of operation each day, including holidays. Providers must ensure the adherence of minimum

staff coverage during established hours of operation, including the implementation of any needed backup plans to ensure such coverage.

Supervision of Non-Licensed Staff

7. Supervision must be provided in a culturally sensitive manner that represents the cultural needs and characteristics of the staff, the service area, and the population being served; and
8. Supervision of RPSSs and RFPSSs must be provided by an LMHP who has successfully completed an Office of Behavioral Health (OBH) approved peer specialist supervisor training. Supervisors shall complete the peer specialist supervisor training within six months of hire.

Documentation

All crisis providers shall maintain case records that include, at a minimum:

1. Name of the member, and if the member is a minor under the age of 18, name of the parent or person with legal authority to act on the minor's behalf;
9. Consent for Treatment, including: .
   i. **Implied consent during an emergency:** When an emergency exists, consent to treatment for a member of any age is implied. An emergency is defined as a situation wherein: (1) the treatment is medically necessary; and (2) a person authorized to consent is not readily available; and (3) any delay in treatment could reasonably be expected to jeopardize the life or health of the person affected or could reasonably result in disfigurement or impair faculties. La. R.S. § 40:1159.5(A). The provider's case record must document all circumstances regarding the emergency care and the patient's implied consent, including all attempts to obtain consent for treatment; and
   ii. **Consent needed for non-emergencies**: Providers must obtain oral or written consent in accordance with the Louisiana Medical Consent Law, La. R.S. § 1159.1 et seq, when an emergency does not exist or no longer exists. Written consent to treatment is preferred. For treatment of a minor (under the age 18) during a non-emergency, documentation of consent for treatment shall include consent from the minor, parent, or person with legal authority to act on the minor's behalf. La. R.S. §§ 40:1079.1(A), 40:1159.4; see also La. R.S. 40:1157.1.

Provider Qualifications

Agency/Facility

To provide crisis response services, providers must meet the following requirements:

1. Licensure pursuant to La. R.S. 40:2151, et. seq. or La. R.S. 40:2180.12, et. seq.;

   NOTE: Providers that meet the provisions of La. R.S. 40:2151: Providers that meet the provisions of La. R.S. 40:2154, et.seq. shall be licensed by LDH

Health Standards as a Behavioral Health Service provider (BHSP) crisis intervention program in order to participate in the Louisiana Medicaid program and receive Medicaid payments. Mobile crisis response providers shall be licensed by LDH Health Standards as a BHSP crisis intervention-mobile crisis response program in order to operate as a mobile crisis response provider, participate in the Louisiana Medicaid program and receive Medicaid payments. ~~LDH Health Standards has submitted a Notice of Intent to amend the provisions governing the licensing of behavioral health service providers in order to include provisions governing mobile crisis response providers. Once effective, mobile crisis response providers shall become licensed by LDH Health Standards as a BHSP mobile crisis response program in order to operate as a mobile crisis response provider, participate in the Louisiana Medicaid Program and receive Medicaid payments.~~ Existing licensed BHSP crisis intervention programs shall be required to ~~apply for the mobile crisis response program at the time of renewal of their current license~~obtain the appropriate license prior to providing mobile crisis response services.

Staff

Staff must also meet the following requirements:

1. Be at least twenty-four (24) years old;
2. Unlicensed staff must have a minimum of bachelor's degree (preferred) OR an associate's degree and two (2) years of work experience in the human services field OR meet qualifications as either an RPSS or an RFPSS: ~~RPSS qualifications. (~~
    a. For RPSS qualifications, s~~S~~ee the Peer Support Services chapter of the Louisiana Medicaid Behavioral Health Services Provider manual,~~)~~ as well as Appendix D, Peer and Family Support Specialists Approved Curriculum for detailed training and continuing education requirements; and
    b. For RFPSS qualifications, see Appendix D, Peer and Family Peer Support Specialists Approved Curriculum for detailed training and continuing education requirements.

~~4. Pass a Tuberculosis (TB) test prior to employment in accordance with the LAC 51:II.Chapter 5; OR be free from Tuberculosis (TB) in a communicable state as defined by the LAC 51:II.Chapter 5;~~

In addition to requirements for all crisis response services staff, the RFPSS must also meet the following qualifications:

1. Must have lived experience as the caregiver for a child with complex needs inclusive of social, emotional, mental health, and/or substance use concerns, and/or involvement with child welfare or juvenile justice systems;

2. Must have a high school diploma or GED;
3. Must be recognized as a peer specialist by an OBH-approved organization; and
4. Must sign acknowledgement and receipt of Peer Support Specialist Code of Ethics.

Mobile Crisis Response (Effective 3/1/2022) (expansion to ages under 21 effective 04/01/2024)

Components

2. a. Telephonic or face to face follow-up based on a clinical individualized need, with face to face follow-up highly preferred for service delivery to youth;

Eligibility Criteria

For youth, eligibility for initial/emergent crisis services based on "self-identification" that the member is experiencing a crisis includes self-identification by the youth and identification by the current physical caregiver to the youth, under the principle that "the crisis is defined by the caller." The caller, who identifies the crisis and initiates Mobile Crisis Response services for youth, may commonly be an adult currently serving in a caregiving role to the youth in the setting where the crisis is being experienced. This may include, but is not limited to:

1. Caregivers in a home setting, including a parent, legal guardian, foster parent, fictive kin, or other family member serving in a caregiving role in the home or community setting at the time that the youth is experiencing the crisis;
2. Teacher or staff in a school setting where the youth is experiencing a crisis;
3. Care staff at a group home setting where the youth currently resides and where the youth is experiencing the crisis; or
4. A helping professional accompanying the youth at the time of the crisis, such as a pediatrician, FINS worker, or probation officer.

   A child experiencing a sudden change in their living situation, such as removal from a family or foster family home and move to a new family or foster family home, may experience this as a crisis that exceeds the abilities and the resources of those involved to effectively resolve it. A youth or their caregiver self-identifying this experience as a crisis is eligible for MCR services.

   Consent to MCR services for minors less than 18 years old: When the call is initiated by a caller who is not a parent with parental authority or otherwise a person with legal authority to act on behalf of the minor, the caller must attempt to contact the parent, or person with legal authority, to obtain their consent for the minor in crisis to receive MCR services, during the time when

the MCR team is dispatching. (For example, school staff do not have parental authority; therefore school staff must call the parent/guardian during the time when the MCR team is dispatching). If the parent, or person with legal authority, is not readily available, continuous efforts must be made by the caller and the MCR team to reach the parent, or person with legal authority, throughout the minor's intervention.

While unemancipated minors usually need the consent of a parent or guardian before receiving medical care, including behavioral health care, a minor may receive emergency medical treatment to preserve life and prevent serious impairment without consent from a parent or guardian. Specifically, under Louisiana's Medical Consent Law, consent to treatment for a minor is implied when an emergency exists. La. R.S. § 40:1159.5(A).

An emergency is defined as a situation wherein: (1) the treatment is medically necessary; and (2) a person authorized to consent is not readily available; and (3) any delay in treatment could reasonably be expected to jeopardize the life or health of the minor or could reasonably result in disfigurement or impair faculties. Id. In the event the parent, or person with legal authority, refuses to consent to the MCR services for the minor, the intervention must cease once all immediate threats to the child's life are resolved. See Louisiana Children's Code article 1554, which provides that while parents and legal guardians have the right to refuse care for minors, they generally cannot do so if it endangers the child's life.

NOTE: A minor in crisis may consent to the MCR services if they believe they are afflicted with an illness or disease and possess the physical and mental capacity to consent to care. La. R.S. 1079.1(A). Unless otherwise stated by available legal documentation, a youth who is aged 18 years or older can individually consent to MCR services and does not need parental consent. Additionally, a person 18 years of age or older may refuse to consent to medical or surgical treatment as to their own person. La. R.S. § 40:1159.7.

Allowed Places of Service

but should not be the primary mode of service delivery. For youth, the member's natural setting will include but is not limited to a family or foster family home, school, or a group home where the youth currently resides.

Staffing Requirements

The MCR provider shall comply with core staffing requirements within the scope of practice of the license required for the facility or agency to practice in the state of

Louisiana. (See Provider Qualifications in the general section.) In addition, the following core staffing requirements for the program must be followed:

3. RPSS or RFPSS on duty to adequately meet the member's needs.

Exclusions

~~1. The initial MCR contact cannot be rendered in emergency departments (EDs). The MCR provider is allowed to continue a 72-hour encounter if it was initiated prior to the ED visit;~~

Community Brief Crisis Support (CBCS) (Effective 3/1/2022) (expansion to ages under 21 effective 04/01/2024)

As determined by the MCO, CBCS can also be provided to individuals who have experienced a presentation to an emergency department for a reason related to emotional distress.

This level of care involves supporting and collaborating with the member (and for youth, the member's caregiver) to achieve symptom reduction by problem solving and developing useful safety plans that will assist with community tenure.

Components

2.a. Telephonic or face to face follow-up based on clinical individualized need, with face to face follow-up highly preferred for service delivery to youth;

Eligibility Criteria

The medical necessity for these rehabilitative services must be determined by and services recommended by an LMHP or physician to promote the maximum reduction of symptoms and/or restoration of a member ~~aged twenty-one (21) years and over~~ to his/her best age-appropriate functional level. This service will be rendered to eligible members after a referral is made from the MCO, MCR, ~~or~~ BHCC, or CS. Members in crisis who require this service may be using substances during the crisis, and this substance use will not, in and of itself, disqualify them for eligibility for the service.

For youth, eligibility for crisis services based on "self-identification" that the member is experiencing a crisis includes identification by the youth's caregiver. CBCS can be requested by any caregiver and delivered in any setting as defined in the MCR section, above, as long as there is consent for treatment from an individual legally allowed to consent to treatment of the youth.

Allowed Places of Service

For youth, the member's natural setting will include, but is not limited to, a family or foster family home, school, or a group home where the youth currently resides.

Staffing Requirements

3. RPSS or RFPSS on duty to adequately meet the member's needs.

Exclusions

~~CBCS services cannot be rendered in substance use residential facilities, PRFT, or inpatient facilities;~~
~~CBCS services cannot be approved for incarcerated individuals;~~
~~CBCS services are not to be utilized as step down services from other residential or inpatient psychiatric service settings; and~~
~~CBCS services must not duplicate already-approved and accessible behavioral health services with a member's already-established ACT, CPST, or PSR provider. However, this should not prohibit a brief overlap of services that is necessary for a warm handoff to the accepting provider, when appropriate.~~

CBCS services **cannot be**:

1. Rendered in substance use residential facilities, PRFT, or inpatient facilities;
2. Approved for incarcerated individuals; and
3. Utilized as step down services from other residential or inpatient psychiatric service settings.

CBCS services **must not** duplicate already-approved and accessible behavioral health services with a member's already-established ACT, CPST, or PSR provider. However, this should not prohibit a brief overlap of services that is necessary for a warm handoff to the accepting provider, when appropriate.

Billing

1. **Only direct staff face-to-face, in-person time with the member may be billed.** CBCS is a face-to-face intervention with the member present; family or other collaterals may also be involved;

June 2022

Revisions to incorporate soft launch criteria.

Publication date: 6/27/22

Soft Launch

During initial implementation of MCR, BHCC and CBCS, LDH is allowing time for the providers to reach full capacity with regards to hours of operation and staffing. Specifically, during this time providers may have decreased:

1. Hours and days of operation;

2. Hours of availability for the medical director that should commensurate with the program's hours of operation; and
3. Recognized Peer Support Specialist (RPSS).

Provider Qualifications
Agency/Facility
To provide crisis response services, providers must meet the following requirements:

1. Licensure pursuant to La. R.S. 40:2151, et. seq. or La. R.S. 40:2180.12, et. seq.
   NOTE: Providers that meet the provisions of La. R.S. 40:2151:
   Providers that meet the provisions of La. R.S. 40:2154, et.seq. shall be licensed by LDH Health Standards as a Behavioral Health Service provider (BHSP) crisis intervention program in order to participate in the Louisiana Medicaid Program and receive Medicaid payments. LDH Health Standards has submitted a Notice of Intent to amend the provisions governing the licensing of behavioral health service providers in order to include provisions governing mobile crisis response providers. Once effective, mobile crisis response providers shall become licensed by LDH Health Standards as a BHSP mobile crisis response program in order to operate as a mobile crisis response provider, participate in the Louisiana Medicaid Program and receive Medicaid payments. Existing licensed BHSP crisis intervention programs shall be required to apply for the mobile crisis response program at the time of renewal of their current license;

16. Ensures and maintains documentation that all persons employed by the organization complete training in the OBH approved Crisis Response curriculum~~, which shall be updated annually~~. (See Appendix D); and

Mobile Crisis Response (Effective 3/1/2022)
Components

2. Provide follow up to the member and authorized member's caretaker and/or family within twenty-four (24) hours as appropriate and desired by the member and up to seventy-two (72) hours to ensure continued stability post crisis for those not accessing higher levels of care or another crisis service, including but not limited to:
   a. Telephonic or face to face follow-up based on a clinical individualized need; and
   b. Additional calls/visits to the member following the initial crisis response as indicated in order to stabilize the individual in the aftermath of the crisis. If the member indicates no further communication is desired, it must be documented in the member's record.

Billing

1. Only direct staff face-to-face time with the member or family members may be billed for the initial response. MCR is a face-to-face intervention with the member present. Family or other collaterals may also be involved;
2. The initial MCR dispatch per diem covers the first twenty-four (24) hours. Any follow up provided within the first 24 hours is included in the per diem. MCR follow-up services can only be billed for any additional follow up beyond 24 hours and up to 72 hours after dispatch.

February 2022

New chapter added to the manual.

Publication date: 2/24/22

Revision Details to Section 2.3 Outpatient Services – Individual Placement and Support (IPS) of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

August 2022

Revisions made to assist with implementation of the service.

Publication date: 8/16/22

Components

Each IPS specialist carries out all phases of employment service, including intake, engagement, assessment, job placement, job coaching, and follow-along supports before step down to less intensive employment support from another mental health practitioner.

The IPS model is based on an integrated team approach which includes the following:

1. IPS programs are staffed by IPS specialists, who meet frequently with the mental health treatment team to integrate IPS services with mental health treatment. IPS specialists with a caseload of nine (9) or less members participate in bi-weekly client-based individual or group supervision, and mental health treatment team meetings for each team to which they are assigned. Once IPS specialists have a caseload of ten (10) or more members, they participate in weekly client-based individual or group supervision, and mental health treatment team meetings for each team to which they are assigned:
    a. The employment unit has weekly client-based individual or group supervision following the supported employment model in which strategies are identified and job leads are shared. They provide coverage for each other's caseload when needed;
9. Job supports are individualized and continue for as long as each worker wants and needs the support. Members receive different types of support for working a job that are based on the job, member preferences, work history, needs, etc. Once members obtain employment, the IPS specialist and staff from the mental health treatment team provide support as long as members want and benefit from the assistance. The goal is for each

member to work as independently as possible and transition off the IPS caseload when the member is comfortable and successful in their work life;

a. IPS specialists have face-to-face contact within one (1) week before starting a job, within three (3) days after starting a job, weekly for the first month, and at least document efforts to meet with members monthly for a year or more, on average, after working steadily, and desired by members;

Provider Responsibilities

Supervision

The IPS unit has weekly member-based individual or group supervision following the supported employment model in which strategies are identified and job leads are shared. They provide coverage for each other's caseload when needed. When there is good fidelity to this item, the IPS supervisor meets weekly with all the IPS specialists as a group to review client employment goals and progress towards achieving those goals. See Components section number 1 for information regarding caseload and supervision.

New teams

New IPS teams must:

1. Submit documentation to the MCO for contracting purposes including evidence of fidelity to the model including findings of self-evaluation using the IPS Fidelity Scale (https://ipsworks.org/wp-content/uploads/2017/08/IPS-Fidelity-Scale-Eng1.pdf);
   a. The self-evaluation must reflect a ~~minimum~~ baseline score ~~of 80~~ in order to be eligible to provide Medicaid funded services to members.
2. Undergo a fidelity review using the IPS Fidelity Scale by an MCO-identified third party within six (6) months of implementation:
   a. This review must reflect continued improvement toward the desired score of 100 (good fidelity)
   b. The team will implement an MCO approved corrective action plan immediately for any individual IPS Fidelity Scale criterion that rates a one (1), two (2), or three (3);
   c. This plan should be implemented within thirty (30) days of findings or sooner as determined necessary by the MCO to mitigate health and safety issues for members; and
   d. Fidelity is tested every six (6) months for a new program until a score of 100 is reached.

Existing teams

Once a new team achieves a fidelity review score of 100 or above, that team is considered an existing team and must:

1. Participate in fidelity reviews using the IPS Fidelity Scale conducted by the MCO or designee at least annually (every twelve (12) months) or more frequently as prescribed by the MCO; and
2. Maintain a minimum score of 100 and above on the IPS Fidelity Scale or the team will implement a MCO approved corrective action plan and achieve ~~in order to maintain the ability to accept new clients.~~ a minimum score of 100 on the IPS Fidelity Scale within six (6) months in order to maintain the ability to accept new clients.

If a 115 to 125 on the IPS Fidelity Scale is achieved, the team will be deemed as operating with "exceptional practice." MCOs may grant extensions of twenty-four (24) month intervals between fidelity reviews for teams operating with "exceptional practice."

Teams are considered to be operating below acceptable fidelity thresholds if they are achieving less than 100 on the IPS Fidelity Scale after implementing a MCO approved corrective action plan for six (6) months will forfeit the ability to accept new members though they can continue to work with existing members as long as there are no health and safety violations with operations as determined by the MCO or LDH.

Teams shall implement an MCO approved corrective action plan and undergo another fidelity review within ~~three (3)~~ six (6) months by the MCO or designee. If the team achieves at least 100 on the IPS Fidelity Scale in subsequent review, the team can resume accepting new referrals.

Staffing Requirements

At least ~~two full-time~~ one dedicated IPS specialist and an IPS supervisor comprise the employment unit. Peer specialists are members of some IPS teams, who share their own experiences to inspire others to work and build careers.

The requirements for IPS specialist and IPS supervisors are indicated as follows:

IPS Specialist

1. ~~Bachelor's degree in mental health, social services, or business~~ High school diploma is required; Two years post high school experience in employment.
2. One year experience working with people with severe mental illness;
3. Successfully completed IPS training prior to providing services; and
4. Have current IPS Certification or ~~are working towards~~ achieve certification within (2) years.

IPS Peer Specialist (Optional staff, but recommended)

1. Must be a Peer Support Specialist as defined in Section 2.3: Outpatient Services – Peer Support Services; and
2. Have current IPS Certification or ~~are working towards~~ achieve certification within (4) years.

IPS Supervisor

1. Master's degree in rehabilitation counseling or mental health field is preferred; Bachelor's degree is required. Previous experience as an employment specialist is necessary;
2. Experience working with people with severe mental illness;
3. At least one (1) year experience in employment services;
4. Successfully completed IPS training prior to providing services; and
5. Have current IPS certification, or ~~is working towards~~ achieve certification within (2) years.

February 2022

New chapter added to the manual.
Publication date: 2/21/22

Revision Details to Section 2.3 Outpatient Services – Rehabilitation Services of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

July 2023

Revisions made to include telehealth allowances for CPST delivery and the removal of PT AG Behavioral Health Rehabilitation Provider Agency PS 8E CSoC/ Behavioral Health as an allowed provider type.

Publication date: 7/7/23

Effective date for telehealth allowance: 5/1/23

Community Psychiatric Support and Treatment

Telehealth (effective May 1, 2023)

Telemedicine/telehealth is the use of a telecommunications system to render healthcare services when a physician, LMHP, or other qualified professional (see staff qualifications) and a member are not in the same location. Telehealth does NOT include the use of text, e-mail, or facsimile (fax) for the delivery of healthcare services.

The originating site means the location of the member at the time the telehealth services are provided. There is no restriction on the originating site and it can include, but is not limited to, a healthcare facility, school, or the member's home. Distant site means the site at which the physician or other licensed practitioner is located at the time the telehealth services are provided.

CPST may be provided via telecommunication technology when the following criteria is met:

- The telecommunication system used by physicians, LMHPs and other qualified professional must be secure, ensure member confidentiality, and be compliant with the requirements of the Health Insurance Portability and Accountability Act (HIPAA).
- The services provided are within the practitioner's telehealth scope of practice as dictated by the respective professional licensing board and accepted standards of clinical practice.
- The member's record includes informed consent for services provided through the use of telehealth.
- Services provided using telehealth must be identified on claims submission using by appending the modifier "95" to the applicable procedure code and indicating the

correct place of service, either POS 02 (other than home) or 10 (home). Both the correct POS and the 95 modifier must be present on the claim to receive reimbursement.

- Assessments and treatment planning conducted by an LMHP through telehealth shall include synchronous, interactive, real-time electronic communication comprising both audio and visual elements unless clinically appropriate and based on member consent.
- Providers must deliver in-person services when telehealth is not clinically appropriate or when the member prefers in-person services. The provider must document the member's preference for in-person or telehealth.

May 2023

Revisions made to clarify supervision expectations and CPST staff ratios.

Publication date: 5/12/23

Provider Responsibilities
Core Staffing

Mental Health Supervisor

As required pursuant to La. R.S. 40:2162, et seq., a Mental Health Supervisor who, for those BHSPs, which provide Community Psychiatric Support and Treatment Services (CPST) or Psychosocial Rehabilitation Services (PSR) must:

1. Be a fully licensed physician, or currently licensed and in good standing in the state of Louisiana to practice within the scope of all applicable state laws, practice acts, and the individual's professional license, as one of the following:
   a. Medical psychologist;
   b. Licensed psychologist;
   c. Licensed clinical social worker (LCSW);
   d. Licensed professional counselor (LPC);
   e. Licensed marriage and family therapist (LMFT); or
   f. Licensed Advanced Practice Reregistered Nurse (APRN) in adult psychiatric and mental health, and family psychiatric and mental health, or certified nurse specialists in psychosocial, gerontological psychiatric mental health, adult psychiatric and mental health and child-adolescent mental health.
2. Be employed by the BHSP for at least 35 (thirty-five) hours per week; and
3. Assist in the design and evaluation of treatment plans for PSR and CPST services.

Staff Supervision for Non-Licensed Staff ~~Providing PSR and CI~~

Provisionally Licensed Professional Counselor (PLPC), Provisionally Licensed Marriage and Family Therapist (PLMFT), Licensed Master Social Worker (LMSW), Certified Social Worker (CSW) or a psychology intern from an APA approved internship program

delivering CPST and/or PSR, services must be under regularly scheduled supervision in accordance with requirements established by the practitioner's professional licensing board. Proof of the board approved supervision must be held by the MHR agency employing these staff. For the psychology intern, the supervisory plan is acceptable. In addition, these staff who only provide CPST or PSR must receive at least one hour per calendar month of personal supervision and training by the provider agency's mental health supervisor pursuant to La. R.S. 40:2162, et seq. and must be documented according to the requirements listed in numbers 2 and 3 below.
~~Services provided by a non-LMHP must be provided under regularly scheduled supervision listed below and if applicable in accordance with requirements established by the practitioner's professional licensing board under which they are pursuing a license.~~

Non-licensed staff providing PSR (excluding psychology interns) must receive regularly scheduled supervision from a person meeting the qualifications of a psychiatrist or an LMHP (excluding Licensed Addiction Counselors (LACs). ~~per the Act 582).~~ ~~LMHP~~ Mental Health supervisors must have the practice-specific education, experience, training, credentials, and licensure to coordinate an array of mental and/or behavioral health services. Agencies may have more than one ~~LMHP~~ supervisor providing required supervision to non-licensed staff. However, the agency must designate one Clinical Supervisor to fulfill the roles and responsibilities established for the Clinical Supervisor position in the Core Staffing section above. A~~n LMHP~~ supervisor may act in the role of the provider agency's Clinical Supervisor if the individual is qualified to fulfill both roles.

Non-licensed staff providing CI (excluding psychology interns) must receive regularly scheduled supervision from a person meeting the qualifications of a psychiatrist or an LMHP (excluding Licensed Addiction Counselors (LACs)). Psychiatrist/LMHP supervisors must have the practice specific education, experience, training, credentials, and licensure to coordinate an array of mental and/or behavioral health services. Agencies may have more than one psychiatrist/LMHP supervisor providing required supervision to non-licensed staff. However, the agency must designate one Clinical Supervisor to fulfill the roles and responsibilities established for the Clinical Supervisor position in the Core Staffing section above. A psychiatrist/LMHP supervisor may act in the role of the provider agency's Clinical Supervisor if the individual is qualified to fulfill both roles.

CPST Staff Ratio(s)
Caseload size must be based on the needs of the members/families, with an emphasis on successful outcomes and individual satisfaction and must meet the needs identified in the individual treatment plan.

~~The following general ratio (full-time equivalent to Medicaid-eligible) should serve as a guide:~~
~~1. One FTE to 15 youth consumers; and~~
~~2. One FTE to 25 adult consumers.~~

CPST Provider Qualifications
Agency
~~Services must be provided under the supervision of a licensed mental health professional (LMHP) who is acting within the scope of his/her professional license and applicable state law. The term "supervision" refers to clinical support, guidance and consultation afforded to non-licensed staff, and should not be confused with professional board required clinical supervision of individuals pursuing licensure. Such individuals must comply with current, applicable scope of practice and supervisory requirements identified by their respective licensing boards.Agencies providing CPST services must employ at least one full-time physician or full-time LMHP to specifically serve as a full-time mental health supervisor to assist in the design and evaluation of treatment plans for CPST services. LMHPs serving in the role of mental health supervisor for CPST services are restricted to medical psychologist, licensed psychologist, licensed clinical social worker (LCSW), licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), or licensed Advanced Practice Registered Nurse (APRN) with a psychiatric specialization. The term "full-time" means employment by the provider agency for at least 35 hours per week;~~
~~NOTE: The term "supervision" refers to clinical support, guidance and consultation afforded to non-licensed staff, and should not be confused with professional board required clinical supervision of individuals pursuing licensure. Such individuals must comply with current, applicable scope of practice and supervisory requirements identified by their respective licensing boards~~

Staff
~~Services provided by a non-LMHP must be provided under regularly scheduled supervision in accordance with requirements established by the practitioner's professional licensing board.~~

PSR Provider Qualifications
Agency
~~Services must be provided under the supervision of a licensed mental health professional (LMHP) or physician who is acting within the scope of his/her professional license and applicable state law. The term "supervision" refers to clinical support, guidance and consultation afforded to non-licensed staff, and should not be confused with professional board required clinical supervision of~~

~~individuals pursuing licensure. Such individuals must comply with current, applicable scope of practice and supervisory requirements identified by their respective licensing boards.Agencies providing PSR services must employee at least one full-time physician or full-time LMHP to specifically serve as a full-time mental health supervisor to assist in the design and evaluation of treatment plans for PSR services. LMHPs serving in the role of mental health supervisor for PSR services are restricted to medical psychologist, licensed psychologist, licensed clinical social worker (LCSW), licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), or licensed Advanced Practice Registered Nurse (APRN) with a psychiatric specialization. The term "full-time" means employment by the provider agency for at least (thirty-five) 35 hours per week; NOTE: The term "supervision" refers to clinical support, guidance and consultation afforded to non-licensed staff, and should not be confused with professional board required clinical supervision of individuals pursuing licensure. Such individuals must comply with current, applicable scope of practice and supervisory requirements identified by their respective licensing boards.~~

Staff

~~8.Staff providing direct services to adult members must complete an approved PSR training, according to a curriculum approved by OBH prior to providing the service. (See Appendix D);~~
~~9. Staff providing direct services to youth must have documented training related to the psychosocial rehabilitation model(s) utilized in the program;~~

CI Additional Service Criteria

~~The CI provider must receive regularly scheduled clinical supervision from a person meeting the qualifications of an LMHP with experience regarding this specialized mental health service. The term "supervision" refers to clinical support, guidance and consultation afforded to non-licensed staff, and should not be confused with clinical supervision of bachelor's or master's level individuals or provisionally licensed individuals pursuing licensure. Such individuals must comply with current, applicable scope of practice and supervisory requirements identified by their respective licensing boards~~

CI Provider Qualifications

Agency

~~Services must be provided under the supervision of a licensed mental health professional (LMHP) or physician who is acting within the scope of his/her professional license and applicable state law. The term "supervision" refers to clinical support, guidance and consultation afforded to non-licensed staff, and should not be confused with clinical supervision of bachelor's or master's level~~

~~individuals or provisionally licensed individuals pursuing licensure. Such individuals must comply with current, applicable scope of practice and supervisory requirements identified by their respective licensing boards;~~

March 2023

Revisions made to remove the in person supervision requirement and tuberculosis testing.
Publication date: 3/6/23

Staff Supervision for Non-Licensed Staff Providing PSR and CI
~~A maximum of 50% of the individual and group meetings may be telephonic or via a secure Health Insurance Portability and Accountability Act HIPAA compliant online synchronous videoconferencing platform.~~ Texts and/or emails cannot be used as a form of supervision to satisfy this requirement. Any protected health information discussed during supervision must be HIPAA compliant.

CPST Provider Qualifications
Agency
~~Arranges for and maintains documentation that all persons, prior to employment, are free from Tuberculosis (TB) in a communicable state as defined by the LAC 51:II.Chapter 5 to reduce the risk of such infections in members and staff. Results from testing performed over thirty (30) days prior to date of employment will not be accepted as meeting this requirement;~~
Staff
~~Pass a TB test prior to employment~~

PSR Provider Qualifications
Agency
~~Arranges for and maintains documentation that all persons, prior to employment, are free from Tuberculosis (TB) in a communicable state as defined by the LAC 51:II.Chapter 5 to reduce the risk of such infections in members and staff. Results from testing performed over thirty (30) days prior to date of employment will not be accepted as meeting this requirement;~~
Staff
~~Staff rendering PSR services shall be at least three (3) years older than any individual they serve under the age of eighteen (18);~~
~~Pass a TB test prior to employment~~

CI Provider Qualifications
Agency

~~Arranges for and maintains documentation that all persons, prior to employment, are free from Tuberculosis (TB) in a communicable state as defined by the LAC 51:II.Chapter 5 to reduce the risk of such infections in members and staff. Results from testing performed over thirty (30) days prior to date of employment will not be accepted as meeting this requirement;~~

Staff

~~Pass a TB test prior to employment~~

January 2023

Revisions made to clarify expectations for the services and providers and redefine Community Psychiatric Support and Treatment to delineate the service from Psychosocial Rehabilitation. Moved Crisis Stabilization for Youth to the Bed Based section.

Publication date: 12/28/22
Effective date: 1/1/23

Children and Adolescents

~~Services should provide skills building and supports that build on existing strengths and target goals related to these key developmental needs and protective factors.~~

Children/adolescents who are in need of specialized behavioral health services shall be served within the context of the family to assure that family dynamics are addressed and are a primary part of the treatment plan and approach. While a child/adolescent is receiving rehabilitation services, a parent/caregiver and necessary family members should be involved in medically necessary services. The treatment plan and progress notes must indicate the member's parent/caregiver and family are involved in treatment.

When clinically and developmentally appropriate (for instance, when providing services to an adolescent), services may be delivered without the parent/caregiver present, as long as the above standards of parent/caregiver involvement are met throughout treatment. However, particularly when services are delivered to younger children, the majority of the services should be delivered with parent/caregiver participating with the member as the services are delivered, as the most developmentally appropriate, clinically effective service will be delivered with the full engagement and participation of the parent/caregiver.

Following initial authorization, if a member is not progressing and the family is not engaged or participating in treatment, the treatment plan and approach should be updated to assure family involvement before reauthorization is considered.

Adults

The expected outcome for adults is to reduce the disability resulting from mental illness and assist in the recovery and resiliency of the individual. These services are home and community-based and are provided on an as needed basis to assist persons in coping with the symptoms of their illness. In order to meet the criteria for disability, one must exhibit impaired emotional, cognitive or behavioral functioning that is a result of mental illness. This impairment must substantially interfere with role, occupational and social functioning. The intent of rehabilitation services is to minimize the disabling effects on the individual's capacity for independent living, to prevent emergency department utilization and/or limit the periods of inpatient treatment. The principles of recovery are the foundation for rehabilitation services. These services are intended for an individual with a mental health diagnosis only, a co-occurring diagnosis of mental health and substance use disorder or a co-occurring diagnosis of mental health and intellectual/developmental disability.

Assessment for CPST and PSR

1. Each member shall be assessed and shall have a treatment plan developed based on that assessment;
2. Assessments shall be performed by an LMHP, and for children and adolescents shall be completed with the involvement of the primary caregiver;
3. For adults, assessments must be performed prior to receiving CPST and/or PSR and at least once every 365 days until discharge. Assessments must also be performed ~~Assessments must be performed at least every 365 days or as needed,~~ any time there is a significant change to the member's circumstances. See Appendix G-2 for vocational and employment considerations; and
4. For youth, assessments must be performed prior to receiving CPST and/or PSR and at least once every 180 days until discharge. Assessments must also be performed any time there is a significant change to the member's circumstances. For additional details regarding conducting assessments for members 6 to 20 years of age, refer to Appendix G-1.

Monitoring Member Progress

As a part of treatment planning, LMHPs shall monitor progress with accomplishing goals and objectives. Progress may be measured by using one or more of the following methods that may include, but is not limited to:

1. Assessing mental health symptoms; and
2. Assessing the member's level of improved functioning utilizing a variety of methods that may include ratings on standardized assessment tools, checklists, direct observation, role-play, self-report, improved grades, improved attendance at school or work, improved medication compliance, feedback from the member, family, teacher, and other stakeholders, and reduced psychiatric inpatient, emergency room, and/or residential utilization.

When it is determined that a member is making limited to no progress, the LMHP, in collaboration with the treatment team, member and family/caregiver, should update the treatment plan to increase the possibility that a member will make progress. If the member continues to make limited to no progress, the LMHP shall consider if MHR services should continue or if a referral to a different level of service delivered by the same or a different provider may improve progress.

Documentation

The progress note must clearly document that the services provided are related to the member's goals, objectives and interventions in the treatment plan, and are medically necessary and clinically appropriate. Each service/progress note must document the specific interventions delivered including a description of what materials were used when teaching a skill. Service/progress notes should include each member's response to the intervention, noting if progress is or is not being made. Effective documentation includes observed behaviors if applicable and a plan for the next scheduled contact with the member. Each progress note must include sufficient detail to support the length of the contact. The content must be specific enough so a third party will understand the purpose of the contact and supports the service and claims data.

The only staff who may complete a progress note is the staff who delivered the service. It is not permissible for one staff to deliver the service and another staff to document and/or sign the service notes.

Eligibility Criteria

All mental health services must be medically necessary in accordance with LAC 50:I.1101. The medical necessity for services shall be determined by an LMHP or physician who is acting within the scope of their professional license and applicable state law. These rehabilitative services must be determined by and recommended by an LMHP or physician to promote the maximum reduction of symptoms and/or restoration of an individual to his/her best age-appropriate functional level.

Service Utilization

Services are subject to prior authorization. Providers shall submit sufficient documentation to determine medical necessity. Failure to do so may result in a partial or non-authorization for services.

Determine the Appropriate Services and Level of Intensity

Prior to submitting an authorization request, the LMHP in collaboration with the member, family/caregiver, natural supports, and direct care staff shall request services based on each member's assessment/reassessment, treatment history, treatment plan, progress

toward accomplishing goals/objectives, level of member/family engagement, member choice/preference and level of need. The provider shall ensure there is sufficient documentation to support the services requested.

The decision regarding the most effective interventions is based on a member's assessed needs, availability of treating providers in the member's geographic area, member preference, and other factors including a member's readiness for change and member/family level of engagement. Interventions recommended must not be limited to the services delivered by the provider or provider agency conducting the assessment and submitting the authorization request. The member's MCO conducting the authorization review may approve the requested service(s) or may recommend a more clinically appropriate service based on their review.

The intensity, frequency, and duration for any service must be individualized.

Active Intervention vs. Observation

Treatment is the active delivery of an intervention identified on a member's treatment plan. Passive observation of a member without an intervention is not a billable activity. For example, observing a member in school while in class, working on the job site, engaging in a recreational activity, interacting with peers, doing homework, or following directions from a teacher, coach, or principal is observation and is not considered an active billable intervention.

Service Location

Services may be provided at a facility, in the community, or in the individual's place of residence as outlined in the treatment plan. Services shall not be provided at an institute for mental disease (IMD) or secure settings (e.g. jails and prisons). The service location shall be determined based on the member's treatment plan, the service delivered, and the participants involved. The service location or place of service shall be documented on the member's treatment plan and shall be associated with a specific goal or objective. The service location shall be selected based on what is therapeutically appropriate and beneficial to the member.

For youth, providers should deliver services when the parent/caregivers are available. Services may be delivered at school or in a community location if appropriate for the service(s) delivered but should not be the primary location if delivered in isolation of the family/caregiver and natural support. The provider must document how the family is incorporated into the service being delivered outside of the home as the primary location.

The following are required when services are delivered at school:

1. The initial and ongoing assessment must indicate school related needs, which may include, but is not limited to, disruptive behaviors in school, poor school attendance, and difficulties with social and peer interactions in school;
2. Prior to MHR services being delivered in the school setting, each member shall be assessed by an LMHP. This assessment shall include a review of school records and interviews with school personnel. Ongoing reassessment of need shall be conducted by an LMHP to determine if services shall continue with school as a place of service;
3. MHR providers shall collaborate with school personnel to collect data to monitor a member's progress. Data collection may include standardized tools as well as collecting other information to determine if a member is making progress. This shall be documented in the member's record. Data collection is not billable;
4. The member shall not be removed from a core class such as math, science, or English, without written permission from the parent and school personnel. A rationale shall be documented in the member's record. If allowed by the member's school, direct interventions may be delivered in the classroom if medically necessary and on the member's treatment plan. Only observing a member is not billable;
5. Prior to delivering services in a member's school, the provider shall obtain written approval from the school. The written approval shall be filed in the member's record; and
6. Providers delivering services in a member's school shall actively communicate and coordinate services with school personnel and with the member's family/caregiver to avoid service duplication.

Services in locations without the caregiver in attendance, such as school or community settings, shall have written approval by the parent/caregiver filed in each member's record.

Providers must accurately identify and report on each claim where a service took place using the most appropriate CMS place of service code.

Delivering Services to Family Members

The agency owner or staff assigned to provide mental health services shall not be a part of a member's family or a legal dependent. The family includes biological, legal or step first, second, third or fourth degree relatives. Family member means, with respect to an individual:

1. First-degree relatives include parents, spouses, siblings, and children;
2. Second-degree relatives include grandparents, grandchildren, aunts, uncles, nephews, and nieces;
3. Third-degree relatives include great-grandparents, great-grandchildren, great aunts, great uncles, and first cousins; and

4. Fourth-degree relatives include great-great grandparents, great-great grandchildren, and children of first cousins.

Limitations/Exclusions

The following activities are not considered CPST or PSR, including PSH, and are therefore not reimbursable:

1. Activities provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide, or an academic tutor;
2. Child care provided as a substitute for the parent or other individuals responsible for providing care and supervision;
3. Respite care;
4. Teaching job related skills (management of symptoms and appropriate work habits may be taught);
5. Vocational rehabilitation (vocational assessment, job development, job coaching); CPST and PSR can include services, such as interpersonal skills, anger management, etc.) that enable the beneficiary to function in the workplace;
6. Transportation;
7. Staff training;
8. Phone contacts including attempts to reach the member by telephone to schedule, confirm, or cancel appointments;
9. Staff supervision;
10. Completion of paper work when the member and/or their significant others are not present. Requiring members to be present only for documentation purposes is not reimbursable;
11. Team meetings and collaboration exclusively with staff employed or contracted by the provider where the member and/or their family/caregivers are not present;
12. Observation of the member (e.g. in the school setting or classroom);
13. Staff research on behalf of the member;
14. Providers may not set up summer camps and bill the time as a mental health rehabilitation service;
15. All contacts by salaried professionals such as supervisors, administrators, human resources staff, receptionists, etc. that are included in the rate (including meetings, travel time, etc.), are considered indirect costs;
16. Contacts that are not medically necessary;
17. Covered services that have not been rendered;
18. Services rendered that are not in accordance with an approved authorization;
19. Interventions not identified in the member's treatment plan;
20. Services provided to children, spouse, parents, or siblings of the eligible member under treatment or others in the eligible member's life to address problems not directly related to the eligible member's issues and not listed on the member's treatment plan;

21. Services provided that are not within the provider's scope of practice;
22. Any art, movement, dance, or drama therapies; and
23. Any intervention or contact not documented.

Community Psychiatric Support & Treatment

Community Psychiatric Support and Treatment (CPST) is a goal-directed support and solution-focused intervention ~~comprehensive service~~, which focuses on reducing the disability resulting from mental illness, restoring functional skills of daily living, building natural supports, and ~~solution-oriented interventions intended to~~ achieving identified person-centered goals or objectives as set forth in the individualized treatment plan. Services address the individualized mental health needs of the member. Services are directed towards adults, children, and adolescents and will vary with respect to hours, type and intensity of services, depending on the changing needs of each individual. The purpose/intent of CPST services is to provide specific, measurable, and individualized services to each person served. CPST is not intended to be an indefinite, ongoing service. CPST is designed to provide rehabilitation services to individuals who can benefit from off-site rehabilitation or who have not been previously engaged in services, including those who had only partially benefited from traditional treatment. CPST services should be focused on the individual's ability to succeed in the community; to identify and access needed services; and to show improvement in school, work and family function. CPST is a face-to-face intervention with the individual present; however, family or other collaterals may also be involved. Most contacts occur in community locations where the person lives, works, attends school and/or socializes. Services must be provided in locations that meet the needs of the persons served.

Components Performed by an LMHP

1. **Initial and annual assessment**, including the LOCUS/CALOCUS; and
2. **Development of a treatment plan** in collaboration with the member and family if applicable (or other collateral contacts) on the specific strengths and needs, resources, natural supports and individual goals and objectives for the member. The overarching focus is to utilize the personal strengths, resources, and natural supports to reduce functional deficits associated with their mental illness and increase restoration of independent functioning. The treatment plan must include developing a crisis management plan.

Components Performed by an LMHP or other qualified professional (see staff qualifications)

1. **Ongoing monitoring of needs** including triggering an update of the treatment plan by the LMHP if needs change significantly;
2. **Counseling**, including mental health interventions that address symptoms, behaviors, thought processes, that assist the member in eliminating barriers to treatment and identifying triggers. Counseling includes assisting the member with effectively

responding to or avoiding identified precursors or triggers that would impact the member's ability to remain in a natural community location. The use of evidenced based practices/strategies is encouraged; and

3. **Clinical psycho-education** includes using therapeutic interventions to provide information and support to better understand and cope with the illness. The illness is the object of treatment, not the family. The goal is for therapist, members, and families work together to support recovery, including assisting the individual and family members or other collaterals with identifying a potential psychiatric or personal crisis.

~~**Components**~~

~~**Development of a treatment plan**: Includes an agreement with the individual and family members (or other collateral contacts) on the specific strengths and needs, resources, natural supports and individual goals and objectives for that person. The overarching focus is to utilize the personal strengths, resources, and natural supports to reduce functional deficits associated with their mental illness and increase restoration of independent functioning. The agreement should also include developing a crisis management plan.~~

~~**Individual supportive interventions**: Includes problem behavior analysis as well as emotional and behavioral management with the individual member with a focus on developing skills and improving daily functional living skills. The primary focus is on implementing social, interpersonal, self-care, and independent living skill goals in order to restore stability, support functional gains, and adapt to community living. This service should not be billed as therapeutic service by licensed or non-licensed staff. Qualified LMHPs should use the appropriate CPT code when billing individual, family or group therapy.~~

~~**NOTE**: CPST services are rehabilitative services associated with assisting individuals with skillbuilding to restore stability, support functional gains and adapt to community living, and should not be confused, psychotherapy or other clinical treatment, which may only be provided by a licensed professional.~~

~~**Skills building work**: Includes the practice and reinforcement of independent living skills, use of community resources and daily self-care routines. The primary focus is to increase the basic skills that promote independent functioning of the member and to restore the fullest possible integration of the individual as an active and productive member of his or her family, community, and/or culture with the least amount of ongoing professional intervention. Assist the member with effectively responding to or avoiding identified precursors or triggers that would risk their remaining in a natural community location, including assisting the individual and family members or other collaterals with identifying a potential psychiatric or personal crisis, developing a crisis management plan and/or, as appropriate, seeking other supports to restore stability and functioning.~~

CPST Provider Qualifications

Staff

To provide CPST services, staff must meet the following requirements:

1. ~~Prior to January 1, 2019, staff with a master's degree in social work, counseling, psychology or a related human services field could provide all aspects of CPST, including individual supportive behavioral interventions. Human services field was defined as an academic program with a curriculum content in which at least 70 percent of the required courses were in the study of behavioral health or human behavior:~~
2. ~~Other aspects of CPST, except for individual supportive behavioral interventions, could have otherwise been performed by an individual with a bachelor's degree in social work, counseling, psychology or a related human services field or four years of equivalent education and/or experience working in the human services field; and~~
3. ~~Effective on or after January 1, 2019, individuals rendering CPST services must have a minimum of a bachelor's degree from an accredited university or college with a major in counseling, social work, psychology or sociology. Individuals with a master's degree from an accredited university or college with a major in counseling, social work, psychology or sociology may render all aspects of CPST, including individual supportive behavioral interventions. Individuals providing CPST services for a licensed and accredited agency who do not possess the minimum master's degree in counseling, social work, psychology or sociology required to provide master's level CPST services, but who have a minimum of a bachelor's degree in counseling, social work, psychology or sociology, and who met all master's degree qualifications in effect prior to January 1, 2019, may continue to provide master's level CPST services for the same licensed and accredited provider agency. Prior to the individual rendering master's level CPST services for a different provider agency, the individual must meet the minimum requirements in effect as of January 1, 2019.~~

   ~~NOTE – HUMAN SERVICES FIELD: It is LDH's position that master's degrees in Criminal Justice, Education, and Public Administration (among others) do not generally meet the requirements necessary to be considered human services related fields for purposes of providing master's level CPST services. Provider agencies employing individuals with master's degrees in academic majors other than counseling, social work, psychology or sociology for the provision of master's level CPST services must maintain documented evidence in the individual's personnel file that supports the individual's academic program required at least 70% of its core curriculum be in the study of behavioral health or human behavior. Transcripts alone will not satisfy this requirement. A signed letter from the college or university stating the academic program required curriculum in which at least 70% of its required coursework was in the study of~~

~~behavioral health or human behavior will satisfy the requirement. College or university published curriculum (may be published via college/university website) inclusive of required coursework demonstrating the program met the requirement is also acceptable.~~

1. Individuals rendering the assessment and treatment planning components of CPST services must be an LMHP.
2. Effective January 1, 2023, individuals rendering all other components of CPST services must be an LMHP, Provisionally Licensed Professional Counselor (PLPC), Provisionally Licensed Marriage and Family Therapist (PLMFT), Licensed Master Social Worker (LMSW), Certified Social Worker (CSW) or a psychology intern from an APA approved internship program.
3. Services provided by a non-LMHP must be provided under regularly scheduled supervision in accordance with requirements established by the practitioner's professional licensing board.

~~Pass a motor vehicle screen (if duties may involve driving or transporting members);~~

Psychosocial Rehabilitation

Psychosocial rehabilitation shall be manualized or delivered in accordance with a nationally accepted protocol. (See Appendix D for approved curricula.) PSR is directed toward a particular symptom and works on increasing or reducing a particular behavior.

Components

Skills building includes the practice and reinforcement of independent living skills, use of community resources and daily self-care routines. The primary focus is to increase the basic skills that promote independent functioning so the member can remain in a natural community location and achieve developmentally appropriate functioning, and assisting the member with effectively responding to or avoiding identified precursors or triggers that result in functional impairment.

~~NOTE: PSR services are psycho-educational services associated with assisting individuals with skill-building, restoration and rehabilitation, and should not be confused with counseling, psychotherapy or other clinical treatment, which may only be provided by a licensed professional.~~

~~2. Implementing learned skills so the member can remain in a natural community location and achieve developmentally appropriate functioning, and assisting the individual with effectively responding to or avoiding identified precursors or triggers that result in functional impairment.~~

PSR Provider Qualifications

Staff

~~Effective on or after January 1, 2022,~~ Any individual rendering PSR services for a licensed and accredited provider agency must meet the following qualifications:

a. Have a bachelor's degree from an accredited university or college in the field of counseling, social work, psychology, sociology, rehabilitation services, special education, early childhood education, secondary education, family and consumer sciences, criminal justice, or human growth and development; or

b. Have a bachelor's degree from an accredited university or college with a minor in counseling, social work, sociology, or psychology; or

c. Be twenty-one (21) years of age or older as of January 1, 2022, have a high school diploma or equivalency, and have been continuously employed by a licensed and accredited agency providing PSR services since prior to January 1, 2019.

NOTE: Services provided by staff meeting the minimum bachelor's degree requirement may be billed at the master's level if the individual's master's degree is received from an accredited university or college in any field.

~~Pass a motor vehicle screen;~~

~~**Crisis Stabilization**~~

~~Crisis stabilization is intended to provide short-term and intensive supportive resources for the youth and his/her family. The intent of this service is to provide an out-of-home crisis stabilization option for the family in order to avoid psychiatric inpatient and institutional treatment of the youth by responding to potential crisis situations. The goal will be to support the youth and family in ways that will address current acute and/or chronic mental health needs and coordinate a successful return to the family setting at the earliest possible time. During the time the crisis stabilization is supporting the youth, there is regular contact with the family to prepare for the youth's return and his/her ongoing needs as part of the family. It is expected that the youth, family and crisis stabilization provider are integral members of the youth's individual treatment team.~~

~~Transportation is provided between the child/youth's place of residence, other services sites and places in the community. The cost of transportation is included in the rate paid to providers of these services.~~

~~Medicaid cannot be billed for the cost of room and board. Other funding sources reimburse for room and board, including the family or legally responsible party (e.g., Office of Juvenile Justice (OJJ) and Department of Children and Family Services (DCFS)).~~

~~**Components**~~

~~The components of CS services are as follows:~~

~~1. A preliminary assessment of risk, mental status and medical stability and the need for further evaluation or other mental health services must be conducted. This includes contact with the member, family members or other collateral sources (e.g., caregiver, school personnel) with pertinent information for the purpose of a preliminary assessment and/or referral to other alternative mental health services at an appropriate level;~~

~~2. CS includes out of home short-term or extended intervention for the identified Medicaid-eligible individual based on initial and ongoing assessment of needs, including crisis resolution and debriefing;~~

~~3. CS includes follow up with the individual and with the individual's caretaker and/or family members; and~~

~~4. CS includes consultation with a physician or with other qualified providers to assist with the individual's specific crisis.~~

~~**CS Provider Qualifications**~~

~~**Agency**~~

~~To provide crisis stabilization services, the agency must:~~

~~a) Arrange for and maintains documentation that prior to employment (or contracting, volunteering, or as required by law) individuals pass criminal background checks, including sexual offender registry checks, in accordance with all of the below:~~

~~1. The Behavioral Health Service Provider (BHSP) licensing regulations established by the Louisiana Administrative Code (LAC) 48:I.Chapter 56, which includes those for owners, managers, and administrators; any individual treating children and/or adolescents; and any non-licensed direct care staff;~~

~~2. La. R.S. 40:1203.1 *et seq*. associated with criminal background checks of un-licensed workers providing patient care;~~

~~3. La. R.S. 15:587, as applicable; and~~

~~4. Any other applicable state or federal law.~~

b) ~~Not hire individuals failing to meet criminal background check requirements and regulations. Individuals not in compliance with criminal background check requirements and regulations shall not be utilized on an employment, contract nor volunteer basis. Criminal background checks performed over 90 days prior to the date of employment will not be accepted as meeting the criminal background check requirement. Results of criminal background checks are to be maintained in the individual's personnel record;~~

c) ~~Review the Department of Health and Human Services' Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) and the LDH State Adverse Actions website prior to hiring or contracting any employee or contractor that performs services that are compensated with Medicaid/Medicare funds, including but not limited to licensed and non-licensed staff, interns and contractors. Once employed, the lists must be checked once a month thereafter to determine if there is a finding that an employee or contractor has abused, neglected or extorted any individual or if they have been excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General. The provider is prohibited from knowingly employing, contracting with, or retaining the employment of or contract with, anyone who has a negative finding placed on the Louisiana State Adverse Action List, or who have been excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General;~~

NOTE: ~~Providers are required to maintain results in personnel records that checks have been completed. The OIG maintains the LEIE on the OIG website (https://exclusions.oig.hhs.gov) and the LDH Adverse Action website is located at https://adverseactions.ldh.la.gov/SelSearch.~~

d) ~~Arrange for and maintain documentation that all persons, prior to employment, are free from Tuberculosis (TB) in a communicable state via skin testing (or chest exam if recommended by physician) to reduce the risk of such infections in members and staff. Results from testing performed over thirty (30) days prior to date of employment will not be accepted as meeting this requirement;~~

~~e) Establish and maintain written policies and procedures inclusive of drug testing staff to ensure an alcohol and drug-free workplace and a workforce free of substance use. (See Appendix D);~~

~~f) Maintain documentation that all direct care staff, who are required to complete First Aid, cardiopulmonary resuscitation (CPR) and seizure assessment training, complete American Heart Association (AHA) recognized training within 90 days of hire, which shall be renewed within a time period recommended by the AHA. (See Appendix D);~~

~~g) Ensure and maintain documentation that all non-licensed persons employed by the organization complete a documented training in a recognized Crisis Intervention curriculum prior to handling or managing crisis calls, which shall be updated annually;~~

~~h) Maintain documentation for verification of completion of required trainings for all staff;~~

~~i) Be an agency licensed by the Louisiana Department of Health (LDH) or the Department of Children and Family Services (DCFS);~~

~~j) Maintain treatment records that include a copy of the treatment plan, the name of the individual, dates of services provided, nature, content and units of rehabilitation services provided, and progress made toward functional improvement and goals in the treatment plan; and~~

~~k) Supervise the direct service workers (DSWs) that provide the care members receive. The requirement is for the supervisor of the DSW to make an onsite visit to the member's home to evaluate the following:~~

~~The DSW's ability to perform their assigned duties in order to:~~

~~1. Determine whether member is receiving the services that are written in the plan of care;~~

2. Verify that the DSW is actually reporting to the home according to the frequency ordered in the plan of care; and

3. Determine member's satisfaction with the services member is receiving.

Staff

To provide crisis stabilization services, staff must meet the following requirements:

1. Be at least eighteen (18) years of age, and at least three (3) years older than an individual under the age of eighteen (18) that they provide services;

2. Have a high school diploma, general equivalency diploma or trade school diploma in the area of human services, or demonstrate competency or verifiable work experience in providing support to persons with disabilities;

NOTE – HUMAN SERVICES FIELD: It is LDH's position that degrees in Criminal Justice, Education, and Public Administration (among others) do not generally meet the requirements necessary to be considered human services related fields for purposes of providing Crisis Intervention services. Provider agencies employing individuals with degrees in academic majors other than counseling, social work, psychology or sociology for the provision of Crisis Intervention services must maintain documented evidence in the individual's personnel file that supports the individual's academic program required at least seventy percent (70%) of its core curriculum be in the study of behavioral health or human behavior. Transcripts alone will not satisfy this requirement. A signed letter from the college or university stating the academic program required curriculum in which at least seventy percent (70%) of its required coursework was in the study of behavioral health or human behavior will satisfy the requirement. College or university published curriculum (may be published via college/university website) inclusive of required coursework demonstrating the program met the requirement is also acceptable.

3. Satisfactorily complete criminal background check pursuant to the BHSP licensing regulations (LAC 48:I.Chapter 56), La. R.S. 40:1203.1 *et seq*., La. R.S. 15:587 (as applicable), and any applicable state or federal law or regulation;

4. Employees and contractors must not be excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General;

~~5. Direct care staff must not have a finding on the Louisiana State Adverse Action List;~~

~~6. Pass a Tuberculosis (TB) test prior to employment;~~

~~7. Pass drug screening tests as required by agency's policies and procedures;~~

~~8. Complete American Heart Association (AHA) recognized First Aid, CPR and seizure assessment training. Psychiatrists, APRNs/CNSs/PAs, RNs and LPNs are exempt from this training. (See Appendix D);~~

~~9. Pass a motor vehicle screen;~~

~~10. Possess and provide documentation of a valid social security number;~~

~~11. Provide documentation of current cardiopulmonary resuscitation (CPR) and first aid certifications;~~

~~12. Comply with law established by La. R.S. 40:2179 *et seq*., and meet any additional qualifications established under Rule promulgated by LDH in association with this statute;~~

~~13. Use clinical programming and a training curriculum approved by OBH prior to providing the service; and~~

~~14. Operate within their scope of practice license required for the facility or agency to practice in the State of Louisiana.~~

~~CS Allowed Provider Types and Specialties~~

~~a) Center Based Respite Care~~

~~a) Licensed as a home and community-based services (HCBS) provider/ Center-Based Respite per La. R.S. 40:2120.1 *et seq*. and Louisiana Administrative Code (LAC) 48:I.Chapter 50 found at the following website: http://www.doa.la.gov/Pages/osr/lac/Code.aspx; and~~

~~b) Completion of State-approved training according to a curriculum approved by OBH prior to providing the service. (See Appendix D).~~

~~c) PT 83 Center Based Respite Care, PS 8E CSoC/Behavioral Health.~~

~~**b) Crisis Receiving Center**~~

~~a) Licensed per La. R.S. 40:2180.12 and LAC 48:I. Chapters fifty-three (53) and fifty-four (54) found at the following website: http://www.doa.la.gov/Pages/osr/lac/Code.aspx; and~~

~~b) Completion of State-approved training according to a curriculum approved by OBH prior to providing the service. (See Appendix D).~~

~~c) PT AF Crisis Receiving Center, PS 8E CSoC/Behavioral Health.~~

~~**c) Child Placing Agency (Therapeutic Foster Care)**~~

~~a) Licensed as a Child Placing Agency by Department of Children and Family Services under the Specialized Provider Licensing Act (La. R.S. 46:1401-46:1430) and LAC 67:V.Chapter 73, found at the following website: http://www.defs.louisiana.gov/assets/docs/searchable/Licensing/Residential/201603_ChildPlacing.pdf; and~~

~~b) Completion of State-approved training according to a curriculum approved by OBH prior to providing the service. (See Appendix D).~~

~~c) PT AR Therapeutic Foster Care, PS 9F Therapeutic Foster Care.~~

~~**CS Limitations/Exclusions**~~

~~The following services shall be excluded from Medicaid coverage and reimbursement:~~

~~5. Services rendered in an institute for mental disease; and~~

~~6. The cost of room and board. The minimum daily rate on file is an all-inclusive rate.~~

~~Crisis stabilization shall not be provided simultaneously with short-term respite care and shall not duplicate any other Medicaid State Plan service or service otherwise available to the member at no cost.~~

~~**CS Allowed Mode(s) of Delivery**~~

- ~~Individual; and~~
- ~~On-site.~~

January 2022

Revisions made to Psychosocial Rehabilitation staff qualifications.

Publication date: 1/20/22

Psychosocial Rehabilitation
PSR Provider Qualifications
Staff

Staff shall operate under an agency license issued by LDH Health Standards. PSR services may not be performed by an individual who is not under the authority of an agency license.

To provide psychosocial rehabilitation services, staff must meet the following requirements:

1. Effective on or after January 1, 2022, any individual rendering PSR services for a licensed and accredited provider agency must meet the following qualifications:
    a. Have a bachelor's degree from an accredited university or college in the field of counseling, social work, psychology, sociology, rehabilitation services, special education, early childhood education, secondary education, family and consumer sciences, or human growth and development; or
    b. Have a bachelor's degree from an accredited university or college with a minor in counseling, social work, sociology, or psychology; or
    c. Be twenty-one (21) years of age or older as of January 1, 2022, have a high school diploma or equivalency, and have been continuously employed by a licensed and accredited agency providing PSR services since prior to January 1, 2019

~~Prior to January 1, 2019, staff must have been at least eighteen (18) years old and have had a high school diploma or equivalent. Effective on or after January 1, 2019, staff rendering PSR services must have a minimum of a bachelor's degree from an accredited university or college with a major in counseling, social work, psychology or sociology. This can include credentialed peer support specialists as defined by LDH who meet all other qualifications to provide the service. Any individual rendering PSR services for a licensed and accredited agency who does not possess the minimum bachelor's degree~~

~~required to provide PSR services, but who met the qualifications in effect prior to January 1, 2019, may continue to provide PSR services for the same provider agency. Prior to the individual rendering PSR services for a different provider agency, the individual must meet the new minimum requirements in effect.~~

June 2020

Revisions made to clarify treatment plan oversight.

Publication date: 6/20/20

Treatment Plan Oversight

The LMHP must review the treatment plan including the goals, objectives, interventions, places of service, and service participants to ensure each service contact increases the possibility that a member will make progress. To determine if updates are needed, the review must be in consultation with provider staff, the member/caregiver and other stakeholders at least once every 180 days or more often if indicated. The member record must include documentation of the treatment plan review.

The member shall receive a signed copy of the plan upon completion and after each revision. A copy of the treatment plan should also be sent to all of the individuals involved in implementing and monitoring the treatment plan. The treatment plan should not include services that are duplicative, unnecessary or inappropriate. ~~The treatment plan shall be reviewed at least once every 365 days or when there is a significant change in the individual's circumstances.~~

April 2020

Revisions were made to clarify Staff Supervision for Non-Licensed Staff

Publication date: 4/8/20

Staff Supervision for Non-Licensed Staff

- **Effective ~~June~~ July 15, 2020**, staff shall receive a minimum of **four (4)** hours of clinical supervision per month for full time staff and a minimum of **one** (1) hour of clinical supervision per month for part time staff, that shall consist of **no less than one (1) hour of individual supervision**. Each month, the remaining hours of supervision may be in a group setting. Given consideration of caseload and acuity, additional supervision may be indicated.

March 2020

Revisions were made to clarify provider qualifications and incorporate criteria for Staff Supervision for Non-Licensed Staff
Publication date: 3/30/20

Rehabilitation Services for Children, Adolescents and Adults
The following provisions apply to all rehabilitation services for children, adolescents and adults, which include the following:

- Community Psychiatric Support and Treatment;
- Psychosocial Rehabilitation;
- Crisis Intervention; and
- Crisis Stabilization (children and adolescents only).

These rehabilitation services are provided as part of a comprehensive specialized psychiatric program available to all Medicaid eligible children, adolescents and adults with significant functional impairments resulting from an identified mental health disorder diagnosis. The medical necessity for these rehabilitative services must be determined by and services recommended by a licensed mental health professional (LMHP) or physician, ~~or under the direction of a licensed practitioner,~~ to promote the maximum reduction of symptoms and restoration to his/her best age-appropriate functional level.

Service Delivery
Services may be provided at a facility, in the community, or in the individual's place of residence as outlined in the ~~plan of care (POC)~~ treatment plan. Services may be furnished in a nursing facility only in accordance with policies and procedures issued by the Department. Services shall not be provided at an institute for mental disease (IMD).

Assessment ~~and Treatment Planning~~

- ~~Treatment plans shall be based on the assessed needs, and developed by an LMHP or physician in collaboration with direct care staff, the member, family and natural supports, and shall contain goals and interventions targeting areas of risk and need identified in the assessment. All team members, including the member and family, shall sign the treatment plan. The member shall receive a copy of the plan upon completion.~~
- ~~The treatment plan shall be reviewed at least once every 365 days or when there is a significant change in the individual's circumstances.~~

Treatment Plan Development

Treatment plans shall be based on the assessed needs, and developed by an LMHP or physician in collaboration with direct care staff, the member, family and natural

supports, and shall contain goals and interventions targeting areas of risk and need identified in the assessment. All team members, including the member and family, shall sign the treatment plan. The member shall receive a copy of the plan upon completion. (If the member is too young to sign the treatment plan, a caregiver signature is sufficient to sign and receive the treatment plan.)

The goal of the treatment plan is to help ensure measurable improved outcomes, increased strengths, a reduction in risk of harm to self or others, and a reduction in the risk of out of home placements to inpatient and residential care. Based on an assessment/reassessment and informed by the member, parent/caregiver, the written treatment plan must meet the following requirements below.

The treatment plan must include:

- Goals and objectives that are specific, measurable, action oriented, realistic, and time-limited;
- Specific interventions based on the assessed needs that must include reference to training material when delivering skills training;
- Frequency and duration of services that will enable the member to meet the goals and outcomes identified in the treatment plan;
- Services and interventions to support independent community living for transitioning adolescents and adults in the setting of his or her own choice and must support integration in the community, including opportunities to seek employment, engage in community life, control personal resources, and improve functional skills at school, home or in the community;
- Member's strengths, capacities, and preferences;
- Clinical and support needs that are indicated by a psychosocial assessment, Child and Adolescent Level of Care Utilization System (CALOCUS) or Level of Care Utilization System (LOCUS) rating, , and other standardized assessment tools as clinically indicated;
- Place of service(s) for each intervention;
- Staff type delivering each intervention;

- Crisis avoidance interventions including the identification of risk factors and barriers with strategies to overcome them, including individualized back-up plans; and
- Language written in a way that is clearly understandable by the member.

Treatment Plan Oversight

- The treatment plan shall be reviewed at least once every 365 days or when there is a significant change in the individual's circumstances.

Provider Responsibilities

- ~~Non-licensed staff must receive regularly scheduled supervision from a person meeting the qualifications of an LMHP with experience regarding the specialized mental health service. Supervision refers to clinical support, guidance and consultation afforded to unlicensed staff rendering rehabilitation services, and should not be confused with clinical supervision of bachelor 's or master 's level individuals pursuing licensure.~~
- Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR) services provided by staff (holding an individual National Provider Identifier) regardless of employment at multiple agencies shall be limited to a maximum combined total of twelve (12) reimbursable hours of CPST services and PSR services within a calendar day.
  - The twelve-(12) hour limitation shall not apply per individual behavioral
  - health services provider agency, rather it applies per individual rendering provider.
  - The twelve-(12) hour limitation shall not apply to evidence-based practices.
  - There is a maximum combined total of twelve (12) reimbursable hours of CPST services and PSR services unless any of the following conditions are met:
    - The medical necessity of the services is documented through the prior authorization approval for a Medicaid recipient receiving more than twelve (12) hours of CPST and PSR services;
    - The services are billed for a group setting and the total hours worked by an individual rendering provider does not exceed twelve (12) hours per calendar day; or
    - The services are billed for crisis intervention.

Staff Supervision for Non-Licensed Staff

Services provided by a non-LMHP must be provided under regularly scheduled supervision listed below and if applicable in accordance with requirements established by the practitioner's professional licensing board under which they are pursuing a license.

Non-licensed staff must receive regularly scheduled supervision from a person meeting the qualifications of an LMHP (excluding Licensed Addiction Counselors (LACs) per the Act 582). LMHP supervisors must have the practice-specific education, experience, training, credentials, and licensure to coordinate an array of mental and/or behavioral health services. Agencies may have more than one LMHP supervisor providing required supervision to non-licensed staff. However, the agency must designate one Clinical Supervisor to fulfill the roles and responsibilities established for the Clinical Supervisor position in the Core Staffing section above. An LMHP supervisor may act in the role of the provider agency's Clinical Supervisor if the individual is qualified to fulfill both roles.

- Supervision refers to clinical support, guidance and consultation afforded to non-licensed staff rendering rehabilitation services, and should not be replaced by licensure supervision of master 's level individuals pursuing licensure.

- **Effective June 15, 2020**, staff shall receive a minimum of **four (4)** hours of clinical supervision per month for full time staff and a minimum of **one** (1) hour of clinical supervision per month for part time staff, that shall consist of **no less than one (1) hour of individual supervision**. Each month, the remaining hours of supervision may be in a group setting. Given consideration of caseload and acuity, additional supervision may be indicated.

- The LMHP (excluding LACs) supervisor must ensure services are in compliance with the established and approved treatment plan.

- Group supervision means one LMHP supervisor (excluding LACs) and not more than six (6) supervisees in supervision session. Individual and group meetings may be telephonic or via a secure Health Insurance Portability and Accountability Act HIPAA compliant online synchronous videoconferencing platform. Texts and/or emails cannot be used as a form of supervision to satisfy this requirement.

- The supervision with the LMHP must:
  - Occur before initial services on a new member begin and, at a minimum, twice a month preferably every fifteen (15) days (except under extenuating or emergent circumstances that are reflected in the supervisory notes).
  - Progress notes that are discussed in supervision must have the LMHP supervisor signature.
  - Have documentation reflecting the content of the training and/or clinical guidance. The documentation must include:

- Date and duration of supervision;
- Identification of supervision type as individual or group supervision;
- Name and licensure credentials of the LMHP supervisor;
- Name and credentials (provisionally licensed, master's degree, bachelor's degree, or high school degree) of the supervisees;
- The focus of the session and subsequent actions that the supervisee must take;
- Date and signature of the LMHP supervisor;
- Date and signature of the supervisees;
- Member identifier, service and date range of cases reviewed; and
- Start and end time of each supervision session.

Eligibility Criteria
The medical necessity for these rehabilitative services must be determined by, and recommended by, an LMHP or physician~~, or under the direction of a licensed practitioner,~~ to promote the maximum reduction of symptoms and/or restoration of an individual to his/her best age-appropriate functional level.

Additional Adult Eligibility Criteria for Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR)
~~Member~~ Adults receiving CPST and/or PSR must have at least a level of care of three on the LOCUS.
~~Members~~ Adults must meet the Substance Abuse and Mental Health Services Administration (SAMHSA) definition of, serious mental illness (SMI) as evidenced by a rating of three or greater on the functional status domain on the Level of Care Utilization System (LOCUS) rating. In addition to having a diagnosable mental disorder, the condition must substantially interfere with, or limit, one or more major life activities, such as:

- Basic daily living (for example, eating or dressing);
- Instrumental living (for example, taking prescribed medications or getting around the community); and
- Participating in a family, school, or workplace.

~~A member must have a rating of three or greater on the functional status domain on the level of care utilization system (LOCUS).~~

~~Members receiving CPST and/or PSR must have at least a level of care of three on the LOCUS.~~

CPST/PSR/CI/CS Provider Qualifications
Agency

- Arranges for and maintains documentation that prior to employment (or contracting, volunteering, or as required by law) individuals pass criminal background checks, including sexual offender registry checks, in accordance with all of the below:
    - The Behavioral Health Service Provider (BHSP) licensing regulations established by the Louisiana Administrative Code (LAC) 48:I.Chapter 56, which includes those for owners, managers, and administrators; any individual treating children and/or adolescents; and any non-licensed direct care staff;
    - La. R.S. 40:1203.1 *et seq*. associated with criminal background checks of un-licensed workers providing patient care;
    - La. R.S. 15:587, as applicable; and
    - Any other applicable state or federal law.

- Providers shall not hire individuals failing to meet criminal background check requirements and regulations. Individuals not in compliance with criminal background check requirements and regulations shall not be utilized on an employment, contract nor volunteer basis. Criminal background checks performed over ninety (90) days prior to the date of employment will not be accepted as meeting the criminal background check requirement. Results of criminal background checks are to be maintained in the individual's personnel record.
- ~~Arranges for and maintains documentation that all persons, prior to employment, pass criminal background checks through the Louisiana Department of Public Safety, State Police. If the results of any criminal background check reveal that the potential employee (or contractor) was convicted of any offenses against a child/youth or an elderly or disabled person, the provider shall not hire and/or shall terminate the employment (or contract) of such individual. The provider shall not hire an individual with a record as a sex offender nor permit these individuals to work for the provider as a subcontractor. Criminal background checks must be performed as required by R.S. 40:1203.1 et seq., and in accordance with R.S. 15:587 et seq. Criminal background checks performed over 90 days prior to date of employment will not be accepted as meeting this requirement.~~

- The provider must review the Department of Health and Human Services' Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) and the LDH State Adverse Actions website prior to hiring or contracting any employee or contractor that performs services that are compensated with Medicaid/Medicare funds, including but not limited to licensed and non-licensed

staff, interns and contractors. Once employed, the lists must be checked once a month thereafter to determine if there is a finding that an employee or contractor has abused, neglected or extorted any individual or if they have been excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General. The provider is prohibited from knowingly employing, contracting with, or retaining the employment of or contract with, anyone who has a negative finding placed on the Louisiana State Adverse Action List, or who have been excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General.

Providers are required to maintain results in personnel records that checks have been completed. The OIG maintains the LEIE on the OIG website (https://exclusions.oig.hhs.gov) and the LDH Adverse Action website is located at https://adverseactions.ldh.la.gov/SelSearch;

Staff

- Satisfactory completion of criminal background check pursuant to the BHSP licensing regulations (LAC 48:I. Chapter 56), La R.S. 40:1203.1 *et seq*., La R.S. 15:587 (as applicable), and any applicable state or federal law or regulation; ~~Pass criminal background check through the Louisiana Department of Public Safety, State Police prior to employment.~~

- Employees and contractors must not be excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General;

- Direct care staff must not have a finding on the Louisiana State Adverse Action List;

CPST Agency

- Effective May 31, 2018, must be credentialed and participating (contracted) in the provider network of the Medicaid managed care entity to be eligible to receive Medicaid reimbursement unless the provider agency is licensed and accredited, and has an executed single case agreement with the Medicaid managed care entity.
- ~~Effective May 31, 2018, must be credentialed and participating (contracted) in the provider network of the Medicaid managed care entity to which the provider intends to submits claims for Medicaid services and to be eligible to receive Medicaid reimbursement, unless the provider agency is licensed and accredited, and has an executed single case agreement with the Medicaid managed care~~

~~entity. executes a single case agreement with a licensed and accredited provider agency not in its network.~~

Staff

Effective on or after January 1, 2019, individuals rendering CPST services must have a minimum of a bachelor's degree from an accredited university or college ~~in the field of~~ with a major in counseling, social work, psychology or sociology. This can include credentialed peer support specialists as defined by LDH who meet all other the qualifications to provide the service. ~~Effective on or after January 1, 2019,~~ Individuals with a master's degree from an accredited university or college ~~in the field~~ of with a major in counseling, social work, psychology or sociology may render all aspects of CPST, including individual supportive behavioral interventions. Individuals providing CPST services for a licensed and accredited agency ~~Any individual~~ who do~~es~~ not possess the minimum master's degree in counseling, social work, psychology or sociology required to provide master's level CPST services, but who have a minimum of a bachelor's degree in counseling, social work, psychology or sociology, and who met all ~~provider~~ master's degree qualifications in effect prior to January 1, 2019, may continue to provide master's level CPST services for the same licensed and accredited provider agency. Prior to the individual rendering master's level CPST services for a different provider agency, the individual must ~~comply with the minimum master's degree provisions of this section~~ meet the minimum requirements in effect as of January 1, 2019.

NOTE – HUMAN SERVICES FIELD: It is LDH's position that master's degrees in Criminal Justice, Education, and Public Administration (among others) do not generally meet the requirements necessary to be considered human services related fields for purposes of providing master's level CPST services. Provider agencies employing individuals with master's degrees in academic majors other than counseling, social work, psychology or sociology for the provision of master's level CPST services must maintain documented evidence in the individual's personnel file that supports the individual's academic program required at least 70% of its core curriculum be in the study of behavioral health or human behavior. Transcripts alone will not satisfy this requirement. A signed letter from the college or university stating the academic program required curriculum in which at least 70% of its required coursework was in the study of behavioral health or human behavior will satisfy the requirement. College or university published curriculum (may be published via college/university website) inclusive of required coursework demonstrating the program met the requirement is also acceptable.

NOTE – STAFF OF EVIDENCE BASED PROGRAMS: It is LDH's position that staff qualifications established by Act 582 of the 2018 Regular Legislative Session are not inclusive of LDH's recognized mental health rehabilitation evidence based programs (EBPs). LDH acknowledges the importance of staff qualifications aligning with EBP model requirements, recommendations and guidelines in order to adhere to the fidelity of these models. LDH recognizes the following programs as evidence based. Agencies providing these EBP services shall ensure their staff adhere to qualifications and requirements established by the EBP model: Assertive Community Treatment (ACT), Functional Family Therapy (FFT and FFT-CW), Homebuilders®, Multi-Systemic Therapy (MST) and Permanent Supportive Housing (PSH). For more information on PSH requirements, please refer to the Permanent Supportive Housing website under the LDH Office of Aging and Adult Services (OAAS).

- Services must be provided under regularly scheduled supervision of a licensed mental health professional (LMHP) or physician who is acting within the scope of his/her professional license and applicable state law. Effective on or after May 31, 2018, non-licensed individuals rendering CPST services are required to receive at least one hour per calendar month of personal supervision and training by the provider agency's mental health supervisor.

  NOTE: The term "supervision" refers to clinical support, guidance and consultation afforded to non-licensed staff, and should not be confused with professional board required clinical supervision of ~~bachelor's or master's level individuals or provisionally licensed~~ individuals pursuing licensure. Such individuals shall comply with current, applicable scope of practice and supervisory requirements identified by their respective licensing boards.

PSR Staff

- Prior to January 1, 2019, staff must have been at least eighteen (18) years old and have had a high school diploma or equivalent. Effective on or after January 1, 2019, staff rendering PSR services must have a minimum of a bachelor's degree from an accredited university or college with a major in counseling, social work, psychology or sociology. This can include credentialed peer support specialists as defined by LDH who meet all other qualifications to provide the service. Any individual rendering PSR services for a licensed and accredited agency who does not possess the minimum bachelor's degree required to provide PSR services, but who met the qualifications in effect prior to January 1, 2019, may continue to provide PSR services for the same provider agency. Prior to the individual rendering PSR services for a different provider agency, the individual must ~~comply~~

~~with the minimum bachelor's degree provisions of this section~~ meet the new minimum requirements in effect.

CI/CS Staff

NOTE – HUMAN SERVICES FIELD: It is LDH's position that degrees in Criminal Justice, Education, and Public Administration (among others) do not generally meet the requirements necessary to be considered human services related fields for purposes of providing Crisis Intervention services. Provider agencies employing individuals with degrees in academic majors other than counseling, social work, psychology or sociology for the provision of Crisis Intervention services must maintain documented evidence in the individual's personnel file that supports the individual's academic program required at least 70% of its core curriculum be in the study of behavioral health or human behavior. Transcripts alone will not satisfy this requirement. A signed letter from the college or university stating the academic program required curriculum in which at least seventy percent (70%) of its required coursework was in the study of behavioral health or human behavior will satisfy the requirement. College or university published curriculum (may be published via college/university website) inclusive of required coursework demonstrating the program met the requirement is also acceptable.

January 2019

Revised section to clarify provider qualifications. Added details to provider qualifications for CPST and PSR due to legislation passed in 2018.
Publication date: 1/1/19

Community Psychiatric Support & Treatment
Provider Qualifications
Agency
To provide CPST services, agencies must meet the following requirements:

- Licensed – pursuant to La. R.S. 40:2151, et. seq.

- Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or The Joint Commission (TJC). Providers must report any denial, loss of, or any negative change in accreditation status, e.g. suspension, reduction in accreditation status, etc. ~~must be reported~~ in writing within 24 hours of receipt of ~~immediately upon~~ notification to the managed care entities with which the agency contracts or is being reimbursed.

  Prior to January 1, 2019, agencies must apply for accreditation and pay accreditation fees prior to being contracted with or reimbursed by a Medicaid managed care entity, and must maintain proof of accreditation application and fee

payment. Agencies must attain full accreditation within 18 months of the initial accreditation application date.

Effective January 1, 2019, provider agencies must be fully accredited or obtain a preliminary accreditation prior to contracting with a Medicaid managed care entity or rendering CPST services. Agencies must provide proof of full accreditation or preliminary accreditation to each managed care entity with which it is contracted. Agencies must maintain proof of continuous, uninterrupted full accreditation or preliminary accreditation at all times. Agencies providing CPST services must obtain a full accreditation status within 18 months of the agency's initial accreditation application date and shall provide proof of full accreditation once obtained to each managed care entity with which it is contracted.

NOTE: Preliminary accreditation is defined as an accreditation status granted by an accrediting body to an unaccredited organization meeting certain organizational, administrative and service delivery standards prior to the organization attaining full accreditation status. Note that each national accrediting organization calls the initial, temporary accreditation by a different name, i.e. CARF (preliminary), COA (provisional), TJC (early survey).

- Prior to May 31, 2018, services must be provided under the supervision of a licensed mental health professional (LMHP) or physician who is acting within the scope of his/her professional license and applicable state law. Effective on or after May 31, 2018, agencies providing CPST services must employee at least one full-time physician or full-time LMHP to specifically serve as a full-time mental health supervisor to assist in the design and evaluation of treatment plans for CPST services. LMHPs serving in the role of mental health supervisor for this section are restricted to medical psychologist, licensed psychologist, licensed clinical social worker (LCSW), licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), or licensed Advanced Practice Registered Nurse (APRN) with a psychiatric specialization. For purposes of this section, the term "full-time" means employment by the provider agency for at least 35 hours per week.

- Effective January 1, 2019, has a National Provider Identification (NPI) number, and must include the agency NPI number and the NPI number of the individual rendering CPST services on its behalf on all claims for Medicaid reimbursement for dates of service on or after January 1, 2019.

- Effective May 31, 2018, must be credentialed and participating (contracted) in the provider network of the managed care entity to which the provider intends to submit claims for Medicaid services and reimbursement unless the managed care entity

executes a single case agreement with a licensed and accredited provider agency not in its network.

Staff

To provide CPST services, staff must meet the following requirements:

- Prior to January 1, 2019, staff with a master's degree in social work, counseling, psychology or a related human services field may provide all aspects of CPST, including individual supportive behavioral interventions.

  Effective on or after January 1, 2019, individuals rendering CPST services must have a minimum of a bachelor's degree from an accredited university or college in the field of counseling, social work, psychology or sociology.

  Effective on or after January 1, 2019, individuals with a master's degree from an accredited university or college in the field of counseling, social work, psychology or sociology may render all aspects of CPST, including individual supportive behavioral interventions. Any individual who does not possess the minimal master's degree in counseling, social work, psychology or sociology required to provide master's level CPST services, but who met all provider qualifications in effect prior to January 1, 2019, may continue to provide master's level CPST services for the same provider agency. Prior to the individual rendering master's level CPST services for a different provider agency, the individual must comply with the minimum master's degree provisions of this section.

- Services must be provided under regularly scheduled supervision of a licensed mental health professional (LMHP) or physician who is acting within the scope of his/her professional license and applicable state law. Effective on or after May 31, 2018, non-licensed individuals rendering CPST services are required to receive at least one hour per calendar month of personal supervision and training by the provider agency's mental health supervisor.

- Effective for dates of service rendered on or after January 1, 2019, individuals rendering CPST services for the licensed and accredited provider agency must have an NPI number and that NPI number must be included on any claim submitted by that provider agency for reimbursement.

Psychosocial Rehabilitation
Provider Qualifications
Agency

To provide psychosocial rehabilitation services, agencies must meet the following requirements:

- Licensed pursuant to La. R.S. 40:2151, et. seq.

- Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or The Joint Commission (TJC). Providers must report any denial, loss of, or any negative change in accreditation status, e.g. suspension, reduction in accreditation status, etc. ~~must be reported~~ in writing ~~immediately~~ within 24 hours of receipt of ~~upon~~ notification of such denial, loss of, or any negative change in accreditation status to the managed care entities with which the agency contracts or is being reimbursed.

Prior to January 1, 2019, agencies must apply for accreditation and pay accreditation fees prior to being contracted with or reimbursed by a Medicaid managed care entity, and must maintain proof of accreditation application and fee payment. Agencies must attain full accreditation within 18 months of the initial accreditation application date.

Effective January 1, 2019, provider agencies must be fully accredited or obtain a preliminary accreditation prior to contracting with a Medicaid managed care entity or rendering PSR services. Agencies must provide proof of full accreditation or preliminary accreditation to each managed care entity with which it is contracted. Agencies must maintain proof of continuous, uninterrupted full accreditation or preliminary accreditation at all times. Agencies providing PSR services must obtain a full accreditation status within 18 months of the agency's initial accreditation application date and shall provide proof of full accreditation once obtained to each managed care entity with which it is contracted.

NOTE: Preliminary accreditation is defined as an accreditation status granted by an accrediting body to an unaccredited organization meeting certain organizational, administrative and service delivery standards prior to the organization attaining full accreditation status. Note that each national accrediting organization calls the initial, temporary accreditation by a different name, i.e. CARF (preliminary), COA (provisional), TJC (early survey).

- Prior to May 31, 2018, services must be provided under the supervision of a licensed mental health professional (LMHP) or physician who is acting within the scope of his/her professional license and applicable state law. Effective on or after May 31, 2018, agencies providing PSR services must employee at least one full-time physician or full-time LMHP to specifically serve as a full-time mental health supervisor to assist in the design and evaluation of treatment plans for PSR services. LMHPs serving in the role of mental health supervisor for this section are restricted to medical psychologist, licensed psychologist, licensed clinical social worker (LCSW), licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), or licensed Advanced Practice Registered Nurse (APRN) with a psychiatric specialization. For purposes of this section, the term "full-time" means employment by the provider agency for at least 35 hours per week.

- Effective January 1, 2019, has a National Provider Identification (NPI) number, and must include the agency NPI number and the NPI number of the individual rendering PSR services on its behalf on all claims for Medicaid reimbursement for dates of service on or after January 1, 2019.

- Effective May 31, 2018, must be credentialed and participating (contracted) in the provider network of the managed care entity to which the provider intends to submit claims for Medicaid services and reimbursement unless the managed care entity executes a single case agreement with a licensed and accredited provider agency not in its network.

Staff

To provide psychosocial rehabilitation services, staff must meet the following requirements:

- Prior to January 1, 2019, must be at least 18 years old and have a high school diploma or equivalent. Effective on or after January 1, 2019, must have a minimum of a bachelor's degree from an accredited university or college in the field of counseling, social work, psychology or sociology. Any individual who does not possess the minimal bachelor's degree required to provide PSR services, but who met all provider qualifications in effect prior to January 1, 2019, may continue to provide PSR services for the same provider agency. Prior to the individual rendering PSR services for a different provider agency, the individual must comply with the minimum bachelor's degree provisions of this section. Additionally, the ~~staff~~ individual must be at least three (3) years older than any individual they serve under the age of 18. This can include credentialed peer support specialists as defined by LDH.

- Effective for dates of service rendered on or after January 1, 2019, individuals rendering PSR services for the licensed and accredited provider agency must have an NPI number and that NPI number must be included on any claim submitted by that provider agency for reimbursement.

- Effective on or after May 31, 2018, non-licensed individuals rendering PSR services are required to receive at least one hour per calendar month of personal supervision and training by the provider agency's mental health supervisor.

June 2018

Updated to Provider Requirements and inserted language to include Behavioral Health Service Provider (BHSP) core services.
Publication date: 6/1/18

Effective in accordance with the licensing rule

Provider Responsibilities

- The provider must ensure no staff is providing unsupervised direct care prior to obtaining the results of the statewide criminal background check and addressing the results of the background check, if applicable.

Core Services

The Behavioral Health Service Provider (BHSP) must offer the following required core services to its clients. The BHSP shall provide these services through qualified staff and practitioners to its clients when needed and desired by its clients.

- Assessment;
- Orientation;
- Treatment;
- Client education;
- Consultation with professionals;
- Counseling services;
- Referral;
- Rehabilitation services;
- Crisis mitigation services; and
- Medication management.

Exception: BHSPs **exclusively** providing the evidence-based practice Functional Family Therapy (FFT/FFTCW), Homebuilders® or Multi-Systemic Therapy (MST) are excluded from the requirement to provide medication management. (See Appendices E-2 FFT/FFTCW, E-3 Homebuilders®, and E-4 MST for more information)

The BHSP Crisis Mitigation Plan

Crisis mitigation is defined as a BHSP's assistance to clients during a crisis that provides 24-hour on-call telephone assistance to prevent relapse or harm to self or others, to provide referral to other services, and to provide support during related crises. Referral to 911 or a hospital's emergency department alone does not constitute crisis mitigation services and does not satisfy this BHSP requirement.

The BHSP's crisis mitigation plan shall:

- Identify steps to take when a client suffers from a medical, psychiatric, medication or relapse crisis; and

- Specify names and telephone numbers of staff or contracted entities to assist clients in crisis.

If the BHSP contracts with another entity to provide crisis mitigation services, the BHSP shall have a written contract with the entity provided the crisis mitigation services.

The qualified individual, whether contracted or employed by the BHS provider, shall call the client within 30 minutes of receiving notice of the client's call.

Core Staffing

The BHSP shall abide by the following minimum core staffing requirements. BHSPs shall maintain a personnel file for each employee, contractor, and individual with whom they have an agreement to provide direct care services or to fulfill core and other staffing requirements. Documentation of employment, contracting or agreement must be in writing and executed via written signatures.

The minimum core staffing requirements are:

- Medical Director/Clinical Director;
- Administrator;
- Clinical Supervisor; and
- Nursing Staff.

Medical Director

A Medical Director who is a physician, or an advanced practice registered nurse, or a medical psychologist, with a current, unrestricted license to practice in the state of Louisiana with a minimum of two years of qualifying experience in treating psychiatric disorders.

Exception: BHSPs **exclusively** providing the evidence-based practice Functional Family Therapy (FFT/FFTCW), Homebuilders® or Multi-Systemic Therapy (MST) are excluded from the requirement of having a Medical Director. Such

BHSPs shall have a Clinical Director in accordance with the Clinical Director description below.

The medical director has the following assigned responsibilities:

- Ensures that necessary medical services are provided the meet the needs of the clients;
- Provides oversight for provider policy/procedure, client treatment plans, and staff regarding the medical needs of the clients according to the current standards of medical practice;
- Directs the specific course of medical treatment for all clients;
- Reviews reports of all medically related accidents/incidents occurring on the premises and identifies hazards to the administrator;
- Participates in the development and implementation of policies and procedures for the delivery of services;
- Periodically reviews delivery of services to ensure care meets the current standards of practice; and
- Participates in the development of new programs and modifications.

In addition, the medical director has the following assigned responsibilities or designates the duties to a qualified practitioner:

- Writes the admission and discharge orders;
- Writes and approves all prescription medication orders;
- Develops, implements and provides education regarding the protocols for administering prescription and non-prescription medications on-site;
- Provides consultative and on-call coverage to ensure the health and safety of clients; and
- Collaborates with the client's primary care physician as needed for continuity of the client's care.

NOTE: The Medical Director may also fulfill the role of the Clinical Director, if the individual is qualified to perform the duties of both roles.

Clinical Director

A Clinical Director who, for those BHSPs, which **exclusively** provide the evidence-based practice Functional Family Therapy (FFT/FFTCW), Homebuilders® or Multi-Systemic Therapy (MST):

- Is a licensed psychiatrist, licensed psychologist, licensed clinical social worker (LCSW), licensed professional counselor (LPC), or licensed marriage

and family therapist (LMFT) with a minimum of two years qualifying experience in treating psychiatric disorders and who maintains a current, unrestricted license to practice in the state of Louisiana;

- Has the following assigned responsibilities:
  - Ensures that the necessary services are provided to meet the needs of the clients,
  - Provides oversight for the provider policy/procedure, treatment planning, and staff regarding the clinical needs of the clients according to the current standards of clinical practice,
  - Directs the course of clinical treatment for all clients,
  - Reviews reports of all accidents/incidents occurring on the premises and identifies hazards to the Administrator,
  - Participates in the development and implementation of policies and procedures for the delivery of services,
  - Periodically reviews delivery of services to ensure care meets the current standards of practice, and
  - Participates in the development of new programs and modifications; and
  - Has the following responsibilities or designates the duties to a qualified practitioner:
    - Provides consultative and on-call coverage to ensure the health and safety of clients, and
    - Collaborates with the client's primary care physician and psychiatrist as needed for continuity of the client's care.

Administrator

An Administrator who:

- Has either a bachelor's degree from an accredited college or university or one year of qualifying experience that demonstrates knowledge, experience and expertise in business management;
- Is responsible for the on-site day to day operations of the BHSP and supervision of the overall BHSP's operation; and
- Shall not perform any programmatic duties and/or make clinical decisions unless licensed to do so.

Clinical Supervisor

A Clinical Supervisor who:

- Is a fully licensed LMHP that maintains a current and unrestricted license with its respective professional board or licensing authority in the state of Louisiana;
- Shall be on duty and on call as needed;
- Has a minimum of two years qualifying experience as an LMHP in the provision of services provided by the BHSP; and
- Has the following responsibilities:
    - Provides supervision utilizing evidence-based techniques related to the practice of behavioral health counseling;
    - Serves as resource person for other professionals counseling or providing direct services to clients with behavioral health disorders;
    - Attends and participates in treatment planning activities and discharge planning;
    - Functions as client advocate in treatment decisions;
    - Ensures BHSP adheres to rules and regulations regarding all behavioral health treatment, such as group size, caseload and referrals; and
    - Assists the Medical Director with the development and implementation of policies and procedures.

Nursing Staff

Nursing Staff who:

- Provide nursing care and services under the direction of a registered nurse necessary to meet the needs of clients; and
- Have a valid current nursing license in the state of Louisiana; and
- Meet the medication needs of clients of the BHSP who are unable to self-administer medication, if needed.

NOTE: Nursing services may be provided directly by the BHSP via employed staff, or may be provided or arranged via written contract, agreement, policy, or other document. When not provided directly by the BHSP, the provider shall maintain written documentation of the arrangement.

Revisions made to clarify the medical necessity criteria and target population for mental health services; to add allowance for more frequent assessments and treatment plan updates based on individual needs; to add eligibility criteria for individuals 21 years of age and older; and to update language and revise service authorization requirements. Added details on assessment, treatment planning, eligibility criteria, and service utilization to align with Adult Mental Health Rule published 6/20/18.
Effective date: June 20, 2018

Assessment and Treatment Planning

- Assessments must be performed at least every ~~364~~365 days or as needed any time there is a significant change to the member's circumstances.

- Treatment plans shall be based on the assessed needs, ~~utilizing input from the member, family, natural supports, and treatment team~~ and developed by or in collaboration with an LMHP or physician in collaboration with direct care staff, the member, family and natural supports, and shall contain goals and interventions targeting areas of risk and need identified in the assessment. All team members, including the member and family, shall sign the treatment plan. The member shall receive a copy of the plan upon completion.

- The treatment plan shall be reviewed at least once every 365 days or when there is a significant change in the individual's circumstances.

Eligibility Criteria
Individuals, 21 years of age and older, who meet Medicaid eligibility, shall qualify to receive adult mental health rehabilitation services if medically necessary in accordance with LAC 50:I.1101, if the member presents with mental health symptoms that are consistent with a diagnosable mental disorder, and the services are therapeutically appropriate and most beneficial to the member.

An adult with a diagnosis of a substance use disorder or intellectual/developmental disability without an additional co-occurring qualifying mental health diagnosis shall not meet the criteria for adult mental health rehabilitation services.

Additional Adult Eligibility Criteria for Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR)
Members must meet the Substance Abuse and Mental Health Services Administration (SAMHSA) definition of, serious mental illness (SMI). In addition to having a diagnosable mental disorder, the condition must substantially interfere with, or limit, one or more major life activities, such as:

- Basic daily living (for example, eating or dressing);
- Instrumental living (for example, taking prescribed medications or getting around the community); and
- Participating in a family, school, or workplace.

A member must have a rating of three or greater on the functional status domain on the level of care utilization system (LOCUS).

Members receiving CPST and/or PSR must have at least a level of care of three on the LOCUS.

An adult with longstanding deficits who does not experience any acute changes in their status and has previously met the criteria stated above regarding LOCUS scores, but who now meets a level of care of two or lower on the LOCUS, and needs subsequent medically necessary services for stabilization and maintenance at a lower intensity, may continue to receive CPST services and/or PSR, if deemed medically necessary.

Service Utilization

Services are subject to prior authorization. Services may be provided at a facility, in the community, or in the individual's place of residence as outlined in the treatment plan. Services may be furnished in a nursing facility only in accordance with policies and procedures issued by the department.

May 2018

Revision made to add information concerning the use and completion process of the Member Choice Form.

Publication date: 5/3/18

Member Choice Form and Process

Members may only receive MHR services from one provider at a time with the following exceptions:

1. A member is receiving tenancy support through the Permanent Supportive Housing Program.
2. The behavioral health medical director for the member's health plan makes the determination that it is medically necessary and clinically appropriate to receive services from more than one MHR provider. The justification must be supported by the member's assessment and treatment plan. This decision must be reviewed at each reauthorization. If a member is receiving services from more

than one MHR provider, the providers must have documented coordination of care.

All members must complete and sign a Member Choice Form prior to the start of MHR services and when transferring from one MHR provider to another. The Member Choice Form must be fully completed, signed by all parties, and received by the member's health plan prior to the start of services. The Member Choice Form is required to be part of the member's clinical record and subject to audit upon request. The health plan must monitor this process and ensure no overlapping authorizations, unless it is during a planned transition.

During a transfer, the initial provider should be given a service end date while the new provider must be given a start date by the member's health plan to ensure providers are reimbursed for services delivered. The health plan may allow a minimal amount of overlap between two providers to prevent a gap in services. In members' best interest during a transfer between two providers, it is expected that providers cooperate during the transition. The initial provider should share documentation and ensure a member has prescription refills if needed.

Providers must notify the member's health plan immediately if it is suspected that a member is receiving MHR services from more than one provider to prevent duplication of service providers.

Revision Details to Section 2.3 Outpatient Services - Outpatient Therapy by Licensed Practitioners of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

May 2023

Updated the telehealth requirements.

Publication date: 5/12/23

Provider Qualifications

~~Arrange and maintain documentation that all persons, prior to employment, are free from Tuberculosis (TB) in a communicable state via skin testing (or chest exam if recommended by physician) to reduce the risk of such infections in beneficiaries and staff. Results from testing performed over 30 days prior to date of employment will not be accepted as meeting this requirement~~;

Telehealth

Telemedicine/telehealth is the use of a telecommunications system to render healthcare services when a physician or LMHP and a member are not in the same location. Telehealth does NOT include the use of text, e-mail, or facsimile (fax) for the delivery of healthcare services.

The originating site means the location of the member at the time the telehealth services are provided. There is no restriction on the originating site and it can include, but is not limited to, a healthcare facility, school, or the member's home. Distant site means the site at which the physician or other licensed practitioner is located at the time the telehealth services are provided.

Assessments, evaluations, individual psychotherapy, family psychotherapy, and medication management services may be provided via telecommunication technology when the following criteria is met:

1. The telecommunication system used by physicians and LMHPs must be secure, ensure member confidentiality, and be compliant with the requirements of the Health Insurance Portability and Accountability Act (HIPAA);

2. The services provided are within the practitioner's telehealth scope of practice as dictated by the respective professional licensing board and accepted standards of clinical practice;
3. The member's record includes informed consent for services provided through the use of telehealth;
4. Services provided using telehealth must be identified on claims submission using by appending the modifier "95" to the applicable procedure code and indicating the correct place of service, either POS 02 (other than home) or 10 (home). Both the correct POS and the 95 modifier must be present on the claim to receive reimbursement;
5. Assessments and evaluations conducted by an LMHP through telehealth should include synchronous, interactive, real-time electronic communication comprising both audio and visual elements unless clinically appropriate and based on member consent; and
6. Providers must deliver in-person services when telehealth is not clinically appropriate or when the member requests in-person services.

~~Assessments, evaluations, individual psychotherapy, family psychotherapy, and medication management services may be reimbursed when provided via telecommunication technology.~~

~~LMHP is responsible for acting within the telehealth scope of practice as decided by the respective licensing board. The provider must bill the procedure code (CPT codes) with modifier "95", as well as the correct place of service, either POS 02 (other than home) or 10 (home). Reimbursement will be at the same rate as a face-to-face service.~~

July 2022

Updated the telehealth requirements.

Publication date: 7/6/22

Telehealth

Assessments, evaluations, individual psychotherapy, family psychotherapy, and medication management services may be reimbursed when provided via telecommunication technology. The LMHP is responsible for acting within the telehealth scope of practice as decided by their licensing board. The provider must bill the procedure code (CPT codes) with modifier "95", as well as the correct place of service, either POS 02 (other than home) or 10 (home) ~~place of service POS 02~~. Reimbursement will be at the same rate as a face-to-face service.

August 2021

Updated the provider qualifications.

Publication date: 8/23/21

Provider Qualifications

LPCs may render or offer prevention, assessment, diagnosis, and treatment, which includes psychotherapy of mental, emotional, behavioral, and addiction disorders to individuals, groups, organizations, or the general public by a licensed professional counselor, that is consistent with his/her professional training as prescribed by La. R.S. 37:1101 et seq. ~~However, LPCs may not assess, diagnose, or provide treatment to any individual suffering from a serious mental illness (SMI), when medication may be indicated, except when an LPC, in accordance with industry best practices, consults, and collaborates with a practitioner who holds a license or permit with the Louisiana State Board of Medical Examiners or a Louisiana licensed APRN, who is certified as a psychiatric nurse practitioner.~~ LPCs shall not engage in the practice of psychology or prescribe, either orally or in writing, distribute, dispense, or administer any medications. If intellectual, personality, developmental, or neuropsychological tests are deemed necessary, the licensed professional counselor shall make an appropriate referral. (Reference: Louisiana Mental Health Counselor Licensing Act; Section 1103).

LMFTs may render professional marriage and family therapy and psychotherapy services limited to prevention, assessment, diagnosis, and treatment of mental, emotional, behavioral, relational, and addiction disorders to individuals, couples and families, singly or in groups that is consistent with his/her professional training as prescribed by La. R.S. 37:1101 et seq. ~~However, LMFTs may not assess, diagnose, or provide treatment to any individual suffering from a serious mental illness (SMI), when medication may be indicated, except when an LMFT, in accordance with industry best practices, consults, and collaborates with a practitioner who holds a license or permit with the Louisiana State Board of Medical Examiners or a Louisiana licensed APRN, who is certified as a psychiatric nurse practitioner. (Reference: Louisiana Mental Health Counselor Licensing Act; Section 1103.)~~ LMFTs shall not engage in the practice of psychology or prescribe, either orally or in writing, distribute, dispense, or administer any medications. If intellectual, personality, developmental, or neuropsychological tests are deemed necessary, the licensed marriage and family therapist shall make an appropriate referral. (Reference: Louisiana Mental Health Counselor Licensing Act; Section 1103). All treatment is restricted to marriage and family therapy issues.

LACs, who provide addiction services, must demonstrate competency, as defined by LDH, State law, Addictive Disorders Practice Act and regulations. LACs are not permitted to

diagnose under their scope of practice under State law. LACs providing addiction and/or behavioral health services must adhere to their scope of practice license.

APRNs shall have a valid, current and unrestricted advanced practice registered nurse license, as a nurse practitioner or clinical nurse specialist, issued by the Louisiana State Board of Nursing. APRNs must be nurse practitioner specialists in adult psychiatric and mental health, and family psychiatric and mental health, or certified nurse specialists in psychosocial, gerontological psychiatric mental health, adult psychiatric and mental health and child-adolescent mental health and may practice to the extent that services are within the APRN's scope of practice.

Agency or Group Practice

- The provider must review the Department of Health and Human Services' Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) and the LDH State Adverse Actions website prior to hiring or contracting any employee or contractor that performs services that are compensated with Medicaid/Medicare funds, including but not limited to licensed and non-licensed staff, interns, and contractors. Once employed, the list must be checked once a month thereafter to determine if there is a finding that an employee or contractor has abused, neglected, or extorted any individual, or if they have been excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or by the Department of Health and Human Services' OIG.
- The provider is prohibited from knowingly employing, contracting with, or retaining the employment of or contract with, anyone who has a negative finding placed on the Louisiana State Adverse Action List, or who has been excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or by the Department of Health and Human Services OIG.
- Providers are required to maintain results in personnel records that these checks have been completed. The OIG maintains the LEIE on the OIG website at https://exclusions.oig.hhs.gov), and the LDH Adverse Action website is located at https://adverseactions.ldh.la.gov/SelSearch;

Telehealth

Assessments, evaluations, individual psychotherapy, family psychotherapy, and medication management services may be reimbursed when provided via telecommunication technology. The LMHP is responsible for acting within the telehealth scope of practice as decided by their licensing board. The provider must bill the procedure code (CPT codes) with modifier "95", as well as Place of Service "02". Reimbursement will be at the same rate as a face-to-face service.

~~"Healthcare provider," as used herein, means a person, partnership, limited liability partnership, limited liability company, corporation, facility, or institution licensed or certified by this state to provide health care or professional services as a physician assistant, hospital, nursing home, . . . registered nurse, advanced practice registered nurse, licensed practical nurse, psychologist, medical psychologist, social worker, or licensed professional counselor. See La. R.S. 40:1223.3(3).~~

~~"Telehealth," as used herein, means a mode of delivering healthcare services that utilizes information and communication technologies to enable the diagnosis, consultation, treatment, education, care management, and self-management of patients at a distance from healthcare providers. See La. R.S. 40:1223.3(6). Additionally, "telehealth" means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between a provider and a patient. Telehealth allows services to be accessed when providers are in a distant site and patients are in the originating site. Telehealth facilitates patient self-management and caregiver support for patients.~~

January 2021

Updated the telehealth options.
Publication date: 1/5/21

Telehealth

Assessments, evaluations, individual psychotherapy, family psychotherapy, and medication management services may be reimbursed when provided via telecommunication technology.

August 2020

Updated the service list and telehealth options.
Publication date: 8/4/20

Licensed Practitioner Outpatient Therapy includes:

- ~~Individual~~ Outpatient psychotherapy (individual, family and group);
- ~~Family outpatient psychotherapy; Group outpatient psychotherapy;~~
- Psychotherapy for crisis;
- Psychoanalysis;
- Electroconvulsive therapy;
- Biofeedback;
- Hypnotherapy;
- ~~Mental health~~ Screening, assessment, examination, ~~Evaluation;~~ and ~~T~~testing;
- ~~• Psychosocial and~~ Diagnostic evaluation;
- Medication management; and
- ~~Medication administration; and Individual therapy with medical evaluation and management and case consultation~~
- Case conference* (CSoC only).

*Case Conferences are communications between Licensed Mental Health Professionals (LMHPs) or Psychiatrists for member consultation that is medically necessary for the medical management psychiatric conditions.

Provider Qualifications

Physician must be a~~,~~ psychiatrist or physician assistant ~~PA~~ working under protocol of a psychiatrist. ~~Registered nurse working within the scope of practice.~~

Telehealth

Individual psychotherapy, family psychotherapy, and medication management services may be

reimbursed when provided via telecommunication technology. The LMHP is responsible for acting within the telehealth scope of practice as decided by their licensing board. ~~Consultations, office visits, individual psychotherapy and pharmacological management services may be reimbursed when provided via telecommunication technology~~ The ~~consulting or expert~~ provider must bill the procedure code (CPT codes) with modifier "95", as well as Place of Service "02". Reimbursement will be at the same rate as a face-to-face service. ~~using the GT modifier and will be reimbursed at the same rate as a face-to-face service.~~

"Healthcare provider," as used herein," ~~-~~means a person, partnership, limited liability partnership, limited liability company, corporation, facility, or institution licensed or certified by this state to provide health care or professional services as a physician assistant, hospital, nursing home, . . . registered nurse, advanced practice registered nurse, licensed practical nurse, psychologist, medical psychologist, social worker, or licensed professional counselor. *See* La. R.S. 40:1223.3(3).

~~"~~Telehealth," as used herein, ~~-~~means a mode of delivering healthcare services that utilizes information and communication technologies to enable the diagnosis, consultation, treatment, education, care management, and self-management of patients at a distance from healthcare providers. *See* La. R.S. 40:1223.3(6). Additionally, "t ~~T~~elehealth" means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between a provider and a patient. Telehealth allows services to be accessed when providers are in a distant site and patients are in the originating site. Telehealth facilitates patient self-management and caregiver support for patients. ~~and includes synchronous interactions and asynchronous store and forward transfers.~~

November 2018

Revised section on telehealth to remove reference to billing for 'other licensed professional services' on page 7 of 8.
Publication date: 11/27/18

Telehealth

Consultations, office visits, individual psychotherapy and pharmacological management services may be reimbursed when provided via telecommunication technology. The consulting or expert provider must bill the procedure code (CPT codes) using the GT modifier and will be reimbursed at the same rate as a face-to-face service. ~~The originating site, with the consumer present, may bill as other licensed professional services.~~ "Healthcare provider" means a person, partnership, limited liability partnership, limited liability company, corporation, facility, or institution licensed or certified by this

state to provide health care or professional services as a physician assistant, hospital, nursing home, dentist, registered nurse, advanced practice registered nurse, licensed practical nurse, … psychologist, medical psychologist, social worker, licensed professional counselor…. "Telehealth" means a mode of delivering healthcare services that utilizes information and communication technologies to enable the diagnosis, consultation, treatment, education, care management, and self-management of patients at a distance from healthcare providers. Telehealth allows services to be accessed when providers are in a distant site and patients are in the originating site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

Revision Details to Section 2.3 Outpatient Services – Personal Care Services (PCS) of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

April 2022

Removed NPI requirements for staff.

Publication date: 4/5/22

Provider Qualifications

Agency

~~9. Have a National Provider Identification (NPI) number, and include the agency NPI number and the NPI number of the individual rendering PCS on its behalf on all claims for Medicaid reimbursement, where applicable.~~

Staff

~~13. Have an NPI number which must be included on any claim submitted by that provider agency for reimbursement, where applicable.~~

February 2022

New chapter added to the manual.

Publication date: 2/21/22

Revision Details to Section 2.3 Outpatient Services – Peer Support Services of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

September 2023

Added a provider type.
Publication date: 9/1/23

Eligibility Criteria
Medicaid eligible members who meet medical necessity criteria may receive PSS when recommended by an LMHP or physician within their scope of practice. Members must meet the following criteria:

1. Be 21 years of age or older; and
2. Have a mental illness and/or substance use disorder diagnosis.

In addition to the above criteria, to be eligible to receive PSS services from an Office of Aging and Adult Services (OAAS) certified Permanent Supportive Housing (PSH) provider agency, members must:

1. Be currently receiving PSH services; or
2. Have been transitioned from a nursing facility or been diverted from nursing
3. facility level of care through the My Choice Louisiana program.

Provider Qualifications
PSS must be provided under the administrative oversight of licensed and accredited local governing entities (LGEs) or an OAAS certified PSH providers (as determined by the LDH OAAS). LGEs and OAAS certified PSH provider agencies must meet state and federal requirements for providing PSS.

Staff
Individuals providing PSS must operate under the administrative oversight of a licensed and accredited LGE or an OAAS certified PSH provider agency.

October 2022

Added group therapy as a treatment modality.
Publication date: 10/4/22

Allowed Modes of Delivery

1. Individual;
2. Group;
3. On-site; and
4. Off-site.

Staff Ratios

1. One (1) RPSS to twenty-five (25) active members; and
2. One (1) RPSS to twelve (12) members is maximum group size for adults:

Peer-Facilitated Group Sessions shall focus on the topic areas identified in the Components Section above to assist the member during the recovery process and comply with all areas of the service definition.

August 2021

Changed staff title from Certified Peer Support Specialists (CPSS) with Recognized Peer Support Specialist (RPSS) and revised staff ratios.

Publication date: 8/26/21

Peer Support Services

The PSS are provided by ~~Certified~~ Office of Behavioral Health Recognized Peer Support Specialists (~~CPSS~~RPSS), who are individuals with personal lived experience with recovery from behavioral health conditions and successfully navigating the behavioral health services system.

Staff Ratios

- One (1) RPSS to twenty-five (~~20~~25) active members

RPSS Training

- ~~The CPSS must complete the OBH approved Peer Employment Training, which is a total of 76 hours of classwork, including a written midterm, written and practical final exam, with additional homework.~~ The RPSS employed by the provider agency must successfully complete a comprehensive peer training plan and curriculum that is inclusive of the Core Competencies for Peer Workers, as outlined by the Substance Abuse and Mental Health Services Administration (SAMHSA), and has been approved by the Office of Behavioral Health (OBH). Training must provide the RPSS with a basic set of competencies that complies with the Core Competencies of the profession to perform the peer support function. Successful completion requires obtaining the minimum qualifying score or better on required knowledge and skill assessments.

February 2021

New chapter added to the manual.
Publication date: 2/1/21

Revision Details to Section 2.4 Addiction Services – Opioid Treatment Programs (OTP) of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

March 2023

Added telehealth allowances for LMHPs.

Publication date: 3/6/23

Telehealth

LMHP's providing assessments, evaluations, individual psychotherapy, family psychotherapy, and medication management services offered within Opioid Treatment Programs may be reimbursed when conducted via telecommunication technology. The LMHP is responsible for acting within the telehealth scope of practice as decided by the respective licensing board. The provider must bill the procedure code (CPT codes) with modifier "95", as well as the correct place of service, either POS 02 (other than home) or 10 (home). Reimbursement will be at the same rate as a face-to-face service. Exclusions: Methadone admission visits conducted by the admitting physician within Opioid Treatment Programs are not allowed via telecommunication technology.

December 2021

Added care coordination expectations.

Publication date: 12/21/21

Treatment Services

8. Care Coordination:

a. Services provided to members must include communication and coordination with the other health care providers as it relates to the member's OUD treatment. Coordination with other health care systems shall occur, as needed, to achieve the treatment goal.

January 2021

Added reimbursement methodology.

Publication date: 1/5/21

Physician Examination

A complete physical examination, including a drug screening test, by the OTP's physician must be conducted before admission to the OTP. A full medical exam, including results of serology and other tests, must be completed within 14 days of admission. The physician shall ensure members have a Substance Use or Opioid Use Disorder. The member must have been addicted to opiates ~~An OUD must be present~~ for at least one year before admission for treatment, or meet exception criteria, as set in federal regulations, as determined by a physician.

Reimbursement

Reimbursement for Methadone for OUD treatment will only be made to OTPs, which are federally approved by SAMHSA and the DEA, and regulated by LDH, which includes OBH and HSS. A provider subspecialty code 8V has been established for the OTPs/Methadone clinics as sole source providers.

The 8V subspecialty has two bundled rate options. H0020 will be used for a bundled rate reimbursement for Methadone treatment. H0047 will be used for a bundled rate for Buprenorphine treatment, but excludes the ingredient cost of the medication. Buprenorphine medication will be billed separately using the applicable J-codes (J0571-J0575) depending on dosage amounts.

Bundled rates for the OTPs will facilitate the practical needs of member-centered treatment in the administration of Medication Assisted Treatment (MAT) to integrate the provision of counseling and medical services. It strengthens recovery and decreases recidivism in members diagnosed within the substance use disorder spectrum.

The table below provides an explanation of available codes for the OTPs/Methadone clinics.

Code	*Explanation of Benefits*
H0020	**Methadone Bundled Rate** Bundled rate includes all state and federal regulatory mandated components of treatment. Services include but are not limited to the following: • Medication: This includes the administration, dosing, and dispensing of Methadone as per the member's treatment plan; • Counseling: Members are required to participate in group or individual sessions as part of the member's treatment plan; • Urine Drug Testing: This includes the urine drug testing or other laboratory tests deemed medically necessary; • Physical examinations by a physician or advanced practice registered nurse;

	• Evaluation and management visits; • Case management; and • Laboratory Services. The OTP may be reimbursed for the bundled rate for participants receiving take home doses in accordance with state and federal regulations and the member's treatment plan phase. Guest dosing occurs when a member receives Methadone dosing at another OTP other than their primary/home-based OTP clinic. The guest dosing provider will bill for the bundled rate and provide clinical care, if appropriate, that is coordinated with the "home" provider and Methadone Central Registry (MCR) to ensure correct dosing.
H0047	**Buprenorphine Bundled Rate** Bundled rate includes all components of treatment, except for the Buprenorphine medication. Services include but are not limited to the following: • Assessment and individualized treatment plan, • Individual and group counseling, • Urine Drug Testing or laboratory testing, and • Coordination of medically necessary services. Buprenorphine medication will be billed separately using the applicable J-codes (J0571-J0575) depending on dosage amounts.

October 2020

New chapter added to the manual.
Publication date: 10/7/20
Effective date: 1/20/20

Revision Details to Section 2.4 Addiction Services of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

May 2023

Updated the telehealth requirements.

Publication date: 5/12/23

Provider Qualifications

Agency

~~Arrange and maintain documentation that all persons, prior to employment, are free from Tuberculosis (TB) in a communicable state via skin testing (or chest exam if recommended by physician) to reduce the risk of such infections in beneficiaries and staff. Results from testing performed over 30 days prior to date of employment will not be accepted as meeting this requirement~~;

Staff

~~Pass a TB test prior to employment;~~

Telehealth

Telemedicine/telehealth is the use of a telecommunications system to render healthcare services when a physician or LMHP and a member are not in the same location. Telehealth does NOT include the use of text, e-mail, or facsimile (fax) for the delivery of healthcare services.

The originating site means the location of the member at the time the telehealth services are provided. There is no restriction on the originating site and it can include, but is not limited to, a healthcare facility, school, or the member's home. Distant site means the site at which the physician or other licensed practitioner is located at the time the telehealth services are provided.

Assessments, evaluations, individual psychotherapy, family psychotherapy, and medication management services may be provided via telecommunication technology when the following criteria is met:

1. The telecommunication system used by physicians and LMHPs must be secure, ensure member confidentiality, and be compliant with the requirements of the Health Insurance Portability and Accountability Act (HIPAA);
2. The services provided are within the practitioner's telehealth scope of practice as dictated by the respective professional licensing board and accepted standards of clinical practice;
3. The member's record includes informed consent for services provided through the use of telehealth;
4. Services provided using telehealth must be identified on claims submission using by appending the modifier "95" to the applicable procedure code and indicating the correct place of service, either POS 02 (other than home) or 10 (home). Both the correct POS and the 95 modifier must be present on the claim to receive reimbursement;
5. Assessments and evaluations conducted by an LMHP through telehealth should include synchronous, interactive, real-time electronic communication comprising both audio and visual elements unless clinically appropriate and based on member consent; and
6. Providers must deliver in-person services when telehealth is not clinically appropriate or when the member requests in-person services.

March 2023

Added telehealth allowances for LMHPs.
Publication date: 3/6/23

Telehealth

LMHP's providing assessments, evaluations, individual psychotherapy, family psychotherapy, and medication management services within intensive outpatient or outpatient treatment may be reimbursed when conducted via telecommunication technology. The LMHP is responsible for acting within the telehealth scope of practice as decided by the respective licensing board. The provider must bill the procedure code (CPT codes) with modifier "95", as well as the correct place of service, either POS 02 (other than home) or 10 (home). Reimbursement will be at the same rate as a face-to-face service. Exclusions: Methadone admission visits conducted by the admitting physician within Opioid Treatment Programs are not allowed via telecommunication technology.

January 2020

Added language to the direct care staff requirements.
Publication date: 1/1/20

Provider Qualifications

Agency

- ~~Providers must review the Louisiana Nurse Aide Registry and the Louisiana Direct Service Worker Registry Louisiana Adverse Action website at: https://adversactions.dhh.la.gov/. against him/her;~~

- The provider must review the Louisiana State Adverse Action List prior to hiring any unlicensed direct care staff member. Once employed the registry must be checked at least every six months thereafter, or more often if there is a reason to suspect it is needed, to determine if there is a finding that a direct care staff has abused, neglected or extorted an individual being supported. The provider is prohibited from knowingly employing or contracting with, or retaining the employment of or contract with any unlicensed direct care staff who has had a finding placed on the Louisiana Adverse Action List (https://adverseactions.ldh.la.gov/SelSearch). Results are to be maintained in the individual's personnel record;

- ~~Non-licensed direct care staff have no record of negative findings on the Louisiana Nurse Aide Registry or the Louisiana Direct Service Worker Registry;~~ Direct care staff must not have a finding on the Louisiana Adverse Action List website at: https://adversactions.dhh.la.gov/. against him/her;

June 2019

Clarified language regarding ASAM Levels and Admission guidelines.
Publication date: 6/12/19

Admission guidelines (ASAM Level 2-WM)

ASAM level 2-WM services are available to recipients who meet the following criteria. The recipient exhibits:

- **Acute intoxication and/or withdrawal potential** – Experiencing moderate signs or symptoms of withdrawal, or there is evidence based on the history of substance use and previous withdrawal history, that withdrawal is imminent.
- **Biomedical conditions and complications** – None~~,~~ or sufficiently stable to permit participation in ambulatory withdrawal management in an outpatient setting.

- **Emotional, behavioral or cognitive conditions and complications** – None to moderate. If present, complications can be safely addressed through monitoring, medication and treatment.
- **Readiness to change** – The patient has adequate understanding of ambulatory detoxification and expresses commitment to enter such a program. Member requires structured therapy and a programmatic milieu to promote treatment progress and recovery.
- **Relapse, continued use or continued problem potential** – Member is experiencing an intensification of symptoms related to substance use, which indicate a high likelihood of relapse or continue use or continue problems without close monitoring and support several times a week.
- **Recovery environment** – Sufficient supportive environment, however, member lacks the resources or skills necessary to maintain an adequate level of functioning without services in an ambulatory withdrawal management outpatient setting.

~~Facilities that provide ASAM level 2-WM ambulatory withdrawal management services with extended on-site monitoring provides care to patients whose withdrawal signs and symptoms are of moderate intensity but are sufficiently stable enough physically and mentally to permit participation in outpatient treatment. Medical and nursing services must be available on-site during hours of clinic operations and on-call after hours. The focus is on medical stabilization and preparation for transfer to a less intensive level of care.~~

Minimum Standards of Practice (ASAM Level 3.2-WM Adolescent)

- **Toxicology and drug screening**– Toxicology and drug screenings are medically monitored. A physician may waive drug screening if and when individual signs list of drugs being used and understands that his/her dishonesty could result in severe medical reactions during withdrawal management process.

November 2018

Revised core requirements, provider qualifications, and staffing requirements for the American Society of Addiction Medicine (ASAM) levels outlined in the document. Updated the Addiction chapter to align with the latest ASAM edition and the BHS licensing rule.
Publication date: 11/27/18

Additional Service Criteria
Providers must maintain medical records that include a copy of the assessment/evaluation, treatment plan, the name of the individual, dates of services provided, nature, content, and units of rehabilitation services provided and progress made toward functional improvement and goals in the treatment plan. (See 2.6 Record Keeping.)

~~These ASAM level services cannot be provided in an institute of mental disease (IMD).~~

ASAM levels of care ~~require~~ are subject to prior approval and reviews on an ongoing basis, as determined necessary by LDH to document compliance with the national standards.

Alcohol and Drug Assessment and Referrals ~~Programs~~

Alcohol and drug assessment and referrals ~~programs~~ provide ongoing assessment and referral services for individuals presenting a current or past use pattern of alcohol or other drug use. The assessment is designed to gather and analyze information regarding a member's biopsychosocial, substance use and treatment history ~~current substance use behavior and social, medical and treatment history~~. The purpose of the assessment is to provide sufficient information for problem identification and, if appropriate, substance use-related treatment or referral. A licensed provider shall comply with licensing standards and any further LDH standards outlined below in regard to assessment practices ~~must develop, implement and comply with policies and procedures that establish processes for referrals for a member~~. Once an individual receives an assessment, a staff member shall provide the individual with the identified clinical recommendation. Evaluations shall include the consideration of appropriate psychopharmacotherapy.

Effective date 4/1/19 - There shall be evidence that the member was assessed to determine if Medication Assisted Treatment (MAT) was a viable option of care, based on SUD diagnosis. ~~A licensed provider may conduct an initial screen of an individual's presenting substance use problem before conducting an assessment of the individual. A licensed provider must comply with licensing standards in regard to assessment practices. Once an individual receives an assessment, a staff member must provide the individual with a recommendation for further assessment or treatment and an explanation of that recommendation.~~

Effective date 4/1/19 - SUD providers, when clinically appropriate, shall

- educate members on the proven effectiveness, benefits and risks of Food and Drug Administration approved MAT options for their SUD;
- provide onsite MAT or refer to MAT offsite; and
- document member education, access to MAT and member response in the progress - notes.

Effective date 4/1/19 - Residential SUD providers shall provide MAT onsite or facilitate access to MAT offsite which includes coordinating with the member's health plan for referring to available MAT provider and arranging Medicaid non-emergency medical transportation if other transportation is not available for the patient.

Core Requirements for the Screening, Assessment and Treatment Planning Process:

A triage screening is conducted to determine eligibility and appropriateness (proper member placement) for admission and referral. (The MCO/CSoC contractor ensures that pre-certification requirements are met.)

A comprehensive bio-psychosocial assessment and ASAM 6 Dimensional risk evaluation must be completed prior to admission, which substantiates member placement at the appropriate ASAM level of care. The evaluation must be reviewed and signed by an LMHP.

A physical examination or appropriate referral within 72 hours if indicated by the physician, nursing assessment or screening process.

A drug screening is conducted when the member's history is inconclusive or unreliable.

An appropriate assignment to level of care with referral to other appropriate services as indicated shall be made.

For residential facilities, diagnostic laboratory tests or appropriate referral shall be made as required to prevent spread of contagious/communicable disease, or as indicated by physical examination or nursing assessment.

Treatment plans shall be based on the evaluations to include person-centered goal and objectives. The treatment plan shall be developed within 72 hours within residential facilities with active participation of the individual, family and providers and be based on the individual's condition and the standards of practice for the provision of rehabilitative services. The treatment plan shall identify the medical or remedial services intended to reduce the identified condition, as well as the anticipated outcomes of the individual. The treatment plan shall include a referral to self-help groups such as AA, Al-Anon, and NA. The treatment plan must specify the frequency, amount and duration of services. (See 2.6 Record Keeping.) The treatment plan must be signed by the LMHP or physician responsible for developing the plan. The plan will specify a timeline for re-evaluation of the plan that is, at least, an annual redetermination.

The re-evaluation shall involve the individual, family and providers and include a re-evaluation of plan to determine whether services have contributed to meeting the stated goals. A new treatment plan shall be developed if there is no measureable reduction of disability or restoration of functional level. The new plan shall identify different rehabilitation strategy with revised goals and services. If the services are being provided to a youth enrolled in a wrap-around agency (WAA), the substance use provider must either be on the Child Family Team (CFT) or will work closely with the CFT. Substance use service provision will be part of the youth's plan of care (POC) developed by the team.

Screening, Assessment and Treatment Plan Review (all ASAM Levels)

The treatment plan is reviewed/updated in collaboration with the member, as needed, or at minimum of every -- days or more frequently if indicated by the member's needs and documented accordingly

Staffing Requirements (all ASAM Levels)

- There is at least one LMHP or UP under the supervision of an LMHP on-site when clinical services are being provided;

ASAM Level 1 Outpatient Treatment

These programs offer comprehensive, coordinated and defined services that may vary in level of intensity but are fewer than nine contact hours per week for adults and fewer than six hours a week for adolescents. ~~or less per week~~.

ASAM Level 2.1 Intensive Outpatient Treatment

These programs offer comprehensive, coordinated and defined services that may vary in level of intensity but must be a minimum of nine contact hours per week for adults, ~~18 years of age and older,~~ ~~(~~and a minimum of six hours per week for adolescents, ~~0-17 years of age)~~ at a minimum of three days per week with a maximum of 19 hours per week.

Staffing Requirements (ASAM Level 2-WM)

- There is a clinical supervisor available on-site for supervision as needed and available on call at all times.

Admission Guidelines (ASAM Level 3.2-WM – Adolescent/Adult)

1. Acute intoxication and/or withdrawal potential – The member is experiencing signs and symptoms of withdrawal, or there is evidence that a withdrawal syndrome is imminent (based on history of substance use, age, gender, or previous withdrawal). The patient is assessed as not requiring medications, but requires this level of service to complete detoxification.

2. Biomedical conditions and complications – None or mild.

3. Emotional, behavioral or cognitive conditions and complications – None to Mild severity; need structure to focus on recovery; if stable, a co-occurring disorder capable program is appropriate.

4. Readiness to change – The member has little awareness and needs intervention to engage and stay in treatment, or there is high severity in this dimension.

5. Relapse, continued use or continued problem potential – The member has little awareness and need intervention available to prevent continued use, with imminent dangerous consequences because of cognitive deficits.

6. Recovery environment – The member's recovery environment is not supportive of detoxification and entry into treatment, and the patient does not have sufficient coping skills to safely deal with the problems in their recovery environment or the patient recently has not demonstrated an inability to complete detoxification at a less intensive level of service, as by continued use.

Minimum Standards of Practice (ASAM Level 3.2-WM Adolescent/Adult)

- Toxicology and drug screening ~~- Toxicology and drug screening are not required in this level of care.~~

Admission Guidelines (ASAM Level 3.3 Adult)

3. Emotional, behavioral or cognitive conditions and complications – Mild to moderate severity; need structure to focus on recovery. Mental status is assessed as sufficiently stable to permit the member to participate in therapeutic interventions provided at this level of care. If stable, a co-occurring disorder capable program is appropriate. If not, a co-occurring disorder enhanced program is required. Treatment should be designed to respond to the member's cognitive deficits.

4. Readiness to change – Has little awareness of the need for continuing care or the existence of his/her substance use or mental health problem and need for treatment and thus has limited readiness to change. Despite experiencing serious consequences of effects of SUD the member has marked difficulty in understanding the relationship between his/her substance use, addiction, mental health or life problems and impaired coping skills and level of functioning. and needs intervention to engage and stay in treatment, or there is high severity in this dimension.

5. Relapse, continued use or continued problem potential – Has little awareness and needs intervention available to prevent continued use, he or she is in imminent danger of continued substance use or emotional health problems with dangerous emotional, behavioral or cognitive consequences. The member's cognitive impairment has limited his/her ability to identify and cope with relapse triggers and high-risk situations. He/she requires relapse prevention activities that are delivered at a slower pace, more concretely, and more repetitively in a setting that provides 24-hour structure and support to prevent imminent dangerous consequences with imminent dangerous consequences because of cognitive deficits.

Additional Provider Requirements for ASAM Level 3.3 - Women with Dependent Children Program

- Offer weekly parenting classes in which attendance is required;

- Provide access to ~~Offer~~ to family planning services;

- Staff members have at least eight hours of training in the following areas prior to supervising children:
  - Chemical dependency and its impact on the family;
  - Child development and age-appropriate activities;
  - Child health and safety;
  - Universal precautions;
  - Appropriate child supervision techniques; and
  - Signs of child abuse; or
  - A licensed day care provider pursuant to a written agreement with the provider.

- The provider shall maintain a staff-to-child ratio that does not exceed 1:3 for infants (18 months and younger) and 1:6 for toddlers and children.

- The provider shall address the specialized and therapeutic needs and care for the dependent children and develop an individualized plan of care to address those needs, to include goals, objectives and target dates; and provide age-appropriate education, counseling, and rehabilitation services for children; and

- The daily activity schedule for the children shall include a variety of structured and unstructured age appropriate activities.

Admission Guidelines (ASAM Level 3.5 Adolescent/Adult)

4. Readiness to change: Motivational interventions have not succeeded at a less intensive level of care. Has limited insight or awareness into the need for treatment. Has marked difficulty in understanding the relationship between his/her substance use, addiction, mental health, or life problems and his/her impaired coping skills and level of functioning that may result in severe life consequences from continued use indicating a need for a 24-hour level of care. ~~Has marked difficulty with or opposition to treatment, with dangerous consequences, or there is high severity in this dimension but not in others. The member, therefore, needs ASAM Level 1 placement with inclusion of Motivational Enhancement Therapy (MET). MET is a therapeutic intervention and a component part of the program.~~
5. Relapse, continued use or continued problem potential: Has no recognition of the skills needed to prevent continued use, with imminently dangerous consequences to self or others. Demonstrates a history of repeated incarcerations with a pattern of relapse to substances and uninterrupted use outside of incarceration. Unable to control use of alcohol or other drugs and/or antisocial behaviors with risk of harm to self or others.
6. Recovery environment: Living and social environments has a high risk of neglect or abuse, ~~Environment is dangerous~~, and member lacks skills to cope outside of a highly structured 24-hour setting.

Admission Guidelines for ASAM Level 3.7 – Adult

2. Biomedical conditions and complications – Moderate to severe conditions (which require 24-hour nursing and medical monitoring or active treatment but not the full resources of an acute care hospital). Or the interaction of the patient's biomedical conditions and continued alcohol or drug use places the patient at significant risk of damage to physical health.

3. Emotional, behavioral or cognitive conditions and complications – Moderate to severe psychiatric conditions and complications or history of moderate to high psychiatric decompensation or moderate to high risk of harm to self, other, or property or is in imminent danger of relapse without 24 hour structure and support and medically monitored treatment, including stabilization with psychotropic medications. ~~Moderate to severe conditions and complications (such as diagnosable co-morbid psychiatric disorders or symptoms). These symptoms may not be severe enough to meet diagnostic criteria but interfere or distract from recovery efforts. Examples include:~~
   - ~~Anxiety/hypomanic or depression;~~
   - ~~Cognitive symptoms such as compulsive behaviors, suicidal or homicidal ideation with a recent history of attempts but no specific plan; and/or~~
   - ~~Hallucinations and delusions (without acute risk to self or others) are interfering with abstinence, recovery and stability to such a degree that the individual needs a structured 24-hour, medically monitored (but not medically managed) environment to address recovery efforts.~~

Admission Guidelines (ASAM Level 3.7 WM Adult)

1. Acute intoxication and/or withdrawal potential – Member is experiencing signs and symptoms of severe withdrawal, or there is evidence that a severe withdrawal syndrome is imminent (based on history of substance use, age, gender, or previous withdrawal). There is a strong likelihood that the patient will require medications.

2. Biomedical conditions and complications – Mild to Moderate, but can be managed at level 3.7WM by medical monitoring. Treatment should be designed to respond to the member's medical needs associated with withdrawal management.

3. Emotional, behavioral or cognitive conditions and complications – Mild to moderate severity; need structure to manage comorbid physical, emotional, behavioral or cognitive conditions that can be managed in this setting but which increase the clinical severity of the withdrawal and complicates withdrawal management.

4. Readiness to change – Member has little awareness and needs intervention to engage and stay in treatment, or there is high severity in this dimension.

5. Relapse, continued use or continued problem potential – Member has little awareness and need intervention available to prevent continued use, with imminent dangerous consequences because of cognitive deficits.

6. Recovery environment – Member's recovery environment is not supportive of detoxification and entry into treatment and the patient does not have sufficient coping skills to safely deal with the problems in the recovery environment or the patient recently has demonstrated an inability to complete detoxification at a less intensive level of service, as by continued use.

Admission Guidelines (ASAM Level 4 WM)

Admission to Level 4WM requires meeting the criteria below in dimensions 1, 2, and/or 3. Problems may also exist from mild to severe in dimensions 4, 5, and/or 6, however they are secondary to dimensions 1, 2, and 3 for the 4WM level of care. If the only severity is in dimensions 4, 5, and/or 6 without high severity in 1, 2 and/or 3, then the member does not qualify for level 4WM.

1. Acute intoxication and/or withdrawal potential – Member is experiencing signs and symptoms of severe, unstable withdrawal, or there is evidence that a severe, unstable withdrawal syndrome is imminent (based on history of substance use, age, gender, or previous withdrawal). An acute care setting is required to manage the severity or instability of the withdrawal symptoms.
2. Biomedical conditions and complications –A significant acute biomedical condition that may pose a poses substantial risk of serious or life-threatening consequences during severe, unstable withdrawal or there is risk of imminent withdrawal. The biomedical conditions and complications require 24 hour medical and nursing care and the full resources of an acute care hospital.
3. Emotional, behavioral or cognitive conditions and complications – A significant acute psychiatric or cognitive condition requires a 24 hour medical and nursing acute care setting to stabilize during severe, unstable withdrawal or there is evidence that a severe, unstable withdrawal syndrome is imminent (based on history of substance use, age, gender, or previous withdrawal).
4. Readiness to change – See admission guidelines above.
5. Relapse, continued use or continued problem potential – See admission guidelines above.
6. Recovery environment – See admission guidelines above.

~~**Limitations/Exclusions and Fee Schedules (ASAM Level 4 WM)**~~

~~As outlined in the Medicaid provider manuals and fee schedules, the MCO will pay the provider at the billed amount up to the fee schedule amount noted.~~

Revision Details to Section 2.5 CSoC of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

October 2022

Clarified the staff ratio requirements for Parent Support and Training and Youth Support and Training.
Publication date: 10/4/22

Limitations and Exclusions

1. PST specialist supervisor (1:80 youth). Adjustments to ratios may be granted on a case by case basis with OBH's approval;
2. PST specialist (1:20 youth). Adjustments to ratios may be granted on a case by case basis with OBH's approval;

Limitations and Exclusions

1. YST specialist supervisor (1:80 youth). Adjustments to ratios may be granted on a case by case basis with OBH's approval;
2. YST specialist (1:20 youth). Adjustments to ratios may be granted on a case by case basis with OBH's approval;

May 2021

Clarified the training requirements for Short Term Respite providers.
Publication date: 5/27/21

Provider Qualifications
Staff

- Completion of The Family Involvement Center's Short Term Respite Provider training ~~according to the~~ curriculum approved by OBH prior to providing the service. (See Appendix D.)

January 2020

Added language to the direct care staff requirements for Parent Support and Training, Youth Support and Training, Independent Living/Skills Building and Short-Term Respite Care.
Publication date: 1/1/20

Provider Qualifications

- The provider must review the Department of Health and Human Services' Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) and the LDH State Adverse Actions website prior to hiring or contracting any employee or contractor that performs services that are compensated with Medicaid/Medicare funds, including but not limited to licensed and unlicensed staff, interns and contractors. Once employed, the lists must be checked once a month thereafter to determine if there is a finding that an employee or contractor has abused, neglected or extorted any individual or if they have been excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General. The provider is prohibited from knowingly employing or contracting with, or retaining the employment of or contract with, anyone who has a negative finding placed on the Louisiana State Adverse Action List, or who have been excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General.

  Providers are required to maintain results in personnel records that checks have been completed. The OIG maintains the LEIE on the OIG website (https://exclusions.oig.hhs.gov) and the LDH Adverse Action website is located at https://adverseactions.ldh.la.gov/SelSearch;

Parent Support Specialist, Youth Support Specialist, Transition Coordinator, and staff of Short Term Respite

- Employees and contractors must not be excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General;

- Direct care staff must not have a finding on the Louisiana State Adverse Action List;

July 2018

Revised to remove the fingerprinting specifications on pages 4, 6, 10, and 12.
Publication date: 7/20/18
Effective date: October 6, 2017

April 2018

Revision was made to clarify that parent support and training, youth support and training, and independent living/skills building services are not to be provided in the provider's place of residence (pages 3, 9, and 14).
Publication date: 4/20/18
Effective date: 10/6/17

Please note: These activities may not be delivered in the provider's place of residence.

February 2018

Revisions made to add comprehensive peer training plan and curriculum requirement.
Publication date: 2/23/18
Effective date: 10/6/17

Each FSO is required to have and utilize a comprehensive peer training plan and curriculum, which is inclusive of the Peer Worker Core Competencies, as outlined by the Substance Abuse and Mental Health Services Administration (SAMHSA), and has been approved by the Office of Behavioral Health (OBH)-Coordinated System of Care (CSoC).

Revision Details to Section 2.6 Record Keeping of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

August 2023

Revisions made to improve documentation.
Publication date: 8/11/23

Confidentiality and Protection of Records

3. Written consent of the individual's legal guardian or legal representative ~~to whom the member's rights have been devolved~~ when the member has been declared legally incompetent; or

NOTE: Under no circumstances ~~should~~ shall providers allow staff to take member's case records from the office without appropriate utilization of standard best practices in compliance with all HIPPA standards related to privacy and security.

Member Records

Providers shall maintain case records that include, at a minimum:

1. Member Rights:
    a. Psychiatric Advanced directive and Medical Advanced directive must be reviewed, signed by, and given to the member and/or responsible party, if applicable;
    b. Consent for treatment/Informed consent must be reviewed, signed by, and given to the member and/or responsible party, if applicable;
    c. Informed consent to deliver telemedicine/telehealth services must be reviewed, signed by, and given to the member and/or responsible party, if applicable. The consent form must include the following:
        i. The rationale for using telemedicine/telehealth in place of in person services;
        ii. The risks and benefits of the telemedicine/telehealth, including privacy-related risks;
        iii. Possible treatment alternatives and those risks and benefits; and
        iv. The risks and benefits of no treatment.
    d. Rights to confidentiality must be reviewed, signed by, and given to the member and/or responsible party, if applicable.

2. Name and date of birth of the individual;
    a. Each page of the record shall have a member identifier such as member name, member initials, member's client ID number, etc.
3. Social security number of the individual;
4. Address of the individual;
5. Dates and time of service;
6. Assessments;
7. ~~Copy of the~~ Treatment plans, based on and consistent with the assessment, which include at a minimum:
    a. Indication if treatment plan is an initial or an updated treatment plan;
    b. Goals and objectives, which are specific, measureable, action oriented, realistic and time-limited;
    c. Specific interventions;
    d. Service locations for each intervention;
    e. Staff providing the intervention;
    f. Estimated frequency and duration of service; and
    g. Signatures of the LMHP, member, and ~~guardian~~ responsible party, i.e., guardian/caregiver, if applicable.
    h. Updated when there are significant life changes, achieved goals, or new problems identified; and
    i. Progression made towards all goals.
8. Progress notes;
9. Units of services provided;
10. Crisis plan;
    a. Crisis plan must be directed by the member and/or the responsible party, i.e., guardian/caregiver, if applicable; and
    b. Crisis plan must include signatures of the member and/or the responsible party, i.e., guardian/caregiver, if applicable.
11. Continuity and Coordination of Care:
    a. The record includes PCP name, address, phone number, and documentation of continuity and coordination of care between PCP and the member's treating provider;
    b. The record includes any other treating behavioral health clinician's name, address, phone number, and documentation of continuity and coordination of care between any other treating behavioral health clinician's and the member's treating provider;
    c. The record includes documentation of any referrals made on behalf of the member, if applicable; and
    d. The record must include a signed Release of Information by the member and/or responsible party, i.e., guardian/caregiver, if applicable, for

communication and coordination of care to occur; if member and/or responsible party refuses, then this refusal must be noted within the record.

12. Medication Management, if applicable:
    a. The record must indicate the following:
        i. Medication name;
        ii. Medication type;
        iii. Medication frequency of administration;
        iv. Medication dosage;
        v. Person who administered each medication;
        vi. Medication route;
        vii. Ordered lab work that has been reviewed by the clinician ordering the lab work as evidenced by date and signature of clinician;
        viii. Evidence of member education on prescribed medication including benefits, risks, side effects, and alternatives of each medication;
        ix. The record must include a signed consent for psychotropic medications by the member and/or responsible party, i.e. guardian/caregiver, if applicable; if member and/or responsible party refuses, then this refusal must be noted within the record;
        x. AIMS (Abnormal Involuntary Movement Scale) preformed when appropriate (e.g., member is being treated with antipsychotic medication);
        xi. Initial and ongoing medical screenings are completed for members prescribed antipsychotic medication including but not limited to weight, BMI, labs, and chronic conditions to document ongoing monitoring; and
        xii. Documentation of monitoring medication adherence, efficacy, and adverse effects.
13. Discharge plan
    a. Appointment date and/or time period of follow up with transitioning behavioral health provider and/or primary care physician, if medical comorbidity is present, must be documented on the discharge plan. Provider must document any barriers if unable to schedule an appointment when member is discharged or transitioned to a different level of care;
    b. Provider must ensure collaborative transition of care occurred with the receiving clinician/program as evidenced by documented communication. Provider must document any barriers if unable to communicate with the receiving clinician/program when member is discharged or transitioned to a different level of care; and
    c. Medication profile, if applicable, provided to outpatient provider and to member during transition of care. Provider must document any barriers while

reviewing the transition of care with member or while providing the medication profile to the outpatient provider.

~~14. Advanced directive~~

May 2020

Revisions made to incorporate technical edits and clarify documentation criteria for service progress notes.

Publication date: 5/29/20

Member Records

Providers must have a separate written record for each member served by the provider. For the purposes of continuity of care/support and for adequate monitoring of progress toward outcomes and services received, service providers must have adequate documentation of services offered and provided to members they serve. This documentation is an on-going chronology of activities undertaken on behalf of the member.

Providers shall maintain case records that include, at a minimum:

- Name of the individual;
- Dates and time of service;
- Assessments;
- Copy of the treatment plans, which include at a minimum:
- Goals and objectives, which are specific, measureable, action oriented, realistic and time-limited;
- Specific interventions;
- Service locations for each intervention;
- Staff providing the intervention;
- Estimated frequency and duration of service; and
- Signatures of the LMHP, member, and guardian (if applicable);
- Progress notes;
- Units of services provided;
- Crisis plan;
- Discharge plan; and
- Advanced directive.

A member can sign the assessment and treatment plans electronically. A member's electronic signature will be deemed valid under federal law if it is authorized by state law. Under the Louisiana Uniform Electronic Transactions Act, La. R.S. 9:2601 et seq. ("LUETA") an electronic signature is valid if: (1) signer intentionally, voluntary agrees

to electronically sign the document; (2) the electronic signature is attributable to signer (i.e. be sure to have patient's printed name under signature); and (3) there are appropriate security measures in place which can authenticate the signature and prevent alteration of the signature (i.e. date and signature cannot be modified in the electronic health record).

Organization of Records, Record Entries and Corrections

Organization of individual member records and the location of documents within the record must be consistent among all records. Records must be appropriately thinned so that current material can be easily located in the record. All entries and forms completed by staff in member records must be legible, written in ink (not black) and include the following:

- The name of the person making the entry;
- The signature of the person making the entry;
- The functional title, applicable educational degree and/or professional license of the person making the entry;
- The full date of documentation; and
- Reviewed by the supervisor, if required.

Any error made by the staff in a member's record must be corrected using the legal method which is to draw a line through the incorrect information, write "error" by it and initial the correction. Correction fluid must never be used in a member's records.

Service/Progress Notes

Service/progress notes document the service/progress billed. Service/progress notes must reflect the service delivered and are the "paper trail" for services delivered.

The following information is required to be entered in the service/progress notes to provide a clear audit trail and document claims:

- Name of member;
- Name of provider and employee providing the service(s);
- Service provider contact telephone number;
- Date of service contact;
- Start and stop time of service contact; and
- Content of each delivered service, including the reason for the contact describing the goals/objectives addressed during the service, specific intervention(s), progress made toward functional and clinical improvement.

~~Service/progress notes must be reviewed by the supervisor (if applicable) to ensure that all activities are appropriate in terms of the nature and time, and that documentation is sufficient.~~ A sample of the service/progress notes for each member seen by a non-LMHP must be reviewed by an LMHP supervisor at least monthly or more if needed. The signature of the LMHP attests to the date and time that the review occurred.

The service/progress note must clearly document that the services provided are related to the member's goals, objectives and interventions in the treatment plan, and are ~~deemed~~ medically necessary and clinically appropriate. Each service/progress note must document the specific interventions delivered including a description of what materials were used when teaching a skill. ~~and document the progress of the recipient with very specific information regarding response to the intervention and the plan for next time.~~ Service/progress notes should include each member's response to the intervention, noting if progress is or is not being made. Effective documentation includes observed behaviors if applicable and a plan for the next scheduled contact with the member. Each service/progress note must include sufficient detail to support the length of the contact. The content must be specific enough so a third party will understand the purpose of the contact and supports the service and claims data.

The only staff who may complete a service/progress note is the staff who delivered the service. It is not permissible for one staff to deliver the service and another staff to document and/or sign the service notes.

June 2018

Revisions have been made to add language to the 'Provider Responsibilities' section to ensure alignment with the adult mental health services requirements for maintaining case records. Added details on member record component and service note requirements to align with Adult Mental Health Rule published 6/20/18.
Publication date: 6/29/18

Member Records

Providers shall maintain case records that include, at a minimum:

- the name of the individual;
- the dates and time of service;
- assessments;
- a copy of the treatment plans, which include at a minimum:
    - goals and objectives, which are specific, measureable, action oriented, realistic and time-limited;

  - specific interventions;
  - the service locations for each intervention;
  - the staff providing the intervention; and
  - the dates of service;
- progress notes;
- crisis plan;
- discharge plan; and
- advanced directive.

Service/Progress Notes

- ~~Content of service contact.~~ Content of each delivered service, including the reason for the contact describing the goals/objectives addressed during the service, specific intervention(s), progress made toward functional and clinical improvement.

Revision Details to Appendix A Forms and Links of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

April 2021

Revisions made to Short Term Respite training curriculum.
Publication date: 4/xx/21

~~**Approved Short Term Respite (STR) Curriculum – Youth**~~
~~University of Idaho Respite Care Provider Training Manual https://marketplace.uidaho.edu/C20272_ustores/web/product_detail.jsp?PRODUCTID=1636~~

September 2019

Formatting corrections and removed an inoperable link.
Publication date: 9/4/19

June 2018

Revised to include link to Chapter 1 - General Information and Administration of the Medicaid Services Manual. Added a link to as referenced in section 2.1.
Publication date: 6/29/18

Revision Details to Appendix D Approved Curriculum/ Equivalency Standards of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

November 2023

Revisions made to update criteria throughout section.
Publication date: 11/13/23

Peer Support ~~Services~~ Specialists and Family Peer Support Specialists
Approved Curriculum
The recognized family peer support specialist (RFPSS) employed by the provider agency must successfully complete a comprehensive peer training plan and curriculum that is inclusive of the core competencies for family peer specialists, as outlined by the National Federation of Families for Children's Mental Health (NFFCMH), and has been approved by OBH. Training must provide the RFPSS with a basic set of competencies that complies with the core competencies of the profession to perform the peer support function. Successful completion requires obtaining the minimum qualifying score or better on required knowledge and skill assessments.

The RPSS or RFPSS must complete a minimum of ten (10) continuing education units (CEU) in the tenets of peer (for the RPSS), or family peer (for the RFPSS), support approved by OBH per calendar year.

February 2022

Updated training requirements for Adult Crisis Response providers.
Publication date: 2/23/22

Crisis Response Services (MCR, BHCC, CBCS) for Adults (Effective 3/1/2022 for MCR and CBCS and 4/1/22 for BHCC)

Approved Curriculum

The LSU Center for Evidence to Practice is the OBH-approved trainer for crisis providers. All required initial trainings and ongoing training/coaching are designed and

delivered through the LSU Center for Evidence to Practice. All initial training must be completed prior to delivering services. The training includes the following:

- Topics of training may include but are not limited to the following:
  - Overview of Louisiana's Crisis System Continuum;
  - Crisis 101;
  - Person-Centered, Collaborative Engagements, Shared Decision Making & Voluntary Approach;
  - Stabilization, Regaining Cognitive Functioning and Resolution-Focused;
  - Trauma, Suicide, Mental Illness, Intellectual Disabilities and Substance Use Related to Crisis;
  - Verbal De-Escalation, Basics of Motivation, Empathic Response;
  - Assessment of Risk, Lethality Assessment/Scales;
  - Safety – Yours and Theirs (Safety Planning);
  - Peer Support in Crisis Response;
  - Self-Management Tools for Clients/Community/Consumers;
  - Voices of Those with Lived Experiences (Focus on Crisis);
  - Connecting to Resources/Supports [Urgent Care, Crisis Stabilization, and When Needed, Collaborating with 911, Emergency Departments – Louisiana Mental Health Laws, MCOs] Roles and Responsibilities/Follow-Up Practices;
  - Self-Care, Self-Care Plans, and Sharing for Crisis Responders;
  - Supervision (Who, What, When; Decision Making; Mandatory/Discretionary);
  - Billing and Documentation of Services; and
  - Continuous Quality Improvement Measures and Reporting.

- The following are in-person demonstration skills sessions:
  - Each one teach one (participants assigned to co-teach with trainer the highlights of online/earlier materials);
  - Active listening and empathy team competition;
  - Role plays, scene situations, demonstration (including culturally responsive care); and
  - Coaching sessions (sign-up and expectations).

May 2021

Updated training requirements for Short Term Respite providers.

Publication date: 5/27/21

Short Term Respite Care

Approved Curriculum

The Family Involvement Center's Short Term Respite Provider Training is the OBH-approved curriculum for Short Term Respite (STR) services. This training must be completed prior to delivering STR services. The training curriculum is designed to be delivered in a classroom setting by a trainer at the STR provider agency. The training consists of seven modules and typically takes approximately six hours to deliver, in addition to break time. The training modules include:

- Module 1: Respite Overview
- Module 2: Wraparound and the CFT Process
- Module 3: Family Culture and Values
- Module 4: Understanding Needs
- Module 5: Safety
- Module 6: Responding to Challenging Behaviors
- Module 7: Are you ready to be a Respite Provider?

The Office Behavioral Health approved Short Term Respite Training can be requested from Magellan of Louisiana at LACSOCPROVIDERQUESTIONS@magellanhealth.com. ~~University of Idaho Respite Care Provider Training Manual is the approved curriculum for Short Term Respite (STR) services. (See Appendix A for contact information.)~~

February 2021

Revisions made to add Peer Support Services training plan and curriculum requirement.

Publication date: 2/5/21

Peer Support Services

Approved Curriculum

The Certified Peer Support Specialist (CPSS) employed by the provider agency must successfully complete a comprehensive peer training plan and curriculum that is inclusive of the Core Competencies for Peer Workers, as outlined by the Substance Abuse and Mental Health Services Administration (SAMHSA), and has been approved by the Office of Behavioral Health (OBH). Training must provide the CPSS with a basic set of competencies that complies with the Core Competencies of the profession to perform the peer support function. Successful completion requires obtaining the minimum qualifying score or better on required knowledge and skill assessments.

The CPSS must complete a minimum of ten (10) Continuing Education Units (CEU) in the tenets of peer support approved by OBH per calendar year. Three (3) of the ten (10) CEUs must be in the area of Ethics. The other seven (7) will be in the principles and competencies related to tenets of peer support. Courses which are mandatory job trainings such as blood borne pathogens, sexual harassment, or prohibited political

activity and are neither recovery oriented or related to Peer Support should not be counted towards this continuing education requirement. Documentation of completion of the ten approved CEUs shall be submitted to OBH by December 31 each year; otherwise, the CPSS will be considered to be lapsed. CEU courses may include:

- Wellness and Recovery;
- Cultural Competency;
- Person Centered Care;
- Mutuality;
- Advocacy;
- Communication;
- Conflict Resolution;
- Trauma Informed Care;
- Integrated Care;
- Partnering with Other Professionals;
- Wellness Recovery Action Plan (WRAP);
- Peer Support Whole Health;
- Intentional Peer Support;
- Mental Health First Aid;
- Suicide Prevention;
- Treatment/Discharge Planning;
- Health Insurance Portability and Accountability Act (HIPAA);
- Mandated Reporting;
- Target Health; and
- Chronic Conditions.

Psychosocial Rehabilitation - Adults
Approved Curriculum

The following training programs make up the approved curriculum for PSR services for adults:

- Boston Psychiatric Rehabilitation Model;
- Clubhouse Model; and
- ~~Social Skills Training Model.~~

Resource: Behavioral Health Service) Provider License

Information and regulations associated with the Behavioral Health Service (BHS) license rule may be found on the Louisiana Health Standards Section website available at the following link: https://ldh.la.gov/index.cfm/page/2990. ~~http://dhh.louisiana.gov/index.cfm/directory/detail/7950/catid/154~~.

February 2018

Revisions made to add comprehensive peer training plan and curriculum requirement.

Publication date: 2/23/18

Effective date: 10/6/17

Each FSO is required to have and utilize a comprehensive peer training plan and curriculum, which is inclusive of the Peer Worker Core Competencies, as outlined by the Substance Abuse and Mental Health Services Administration (SAMHSA), and has been approved by the Office of Behavioral Health (OBH)-Coordinated System of Care (CSoC).

Revision Details to Appendix E-1 Evidence Based Practices – Assertive Community Treatment (ACT) of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

October 2023
Revisions were made to change the effective date for ACT program assessment criteria.
Publication date: 10/02/23

Assessment
Utilizing the comprehensive person centered needs assessment, an initial vocational assessment (referred to as the "career profile") in addition to member interviews, shall be completed on all individuals participating in the ACT program within thirty (30) calendar days after program entry for members admitted on or after 107/01/2023, or within ninety (90) calendar days for existing members. The career profile typically occurs over 2-3 sessions by the IPS employment specialist.

June 2023

Revisions made to include Individual Placement and Support (IPS) criteria for Assertive Community Treatment.
Publication date: 6/7/23

> Employment services provided through ACT programming adhere to tenets of the Individual Placement and Support (IPS) model of supported employment. IPS is an evidence-based practice of supported employment for members with mental illness designed to enhance the quality of employment services and overall employment outcomes for members.
>
> The primary goals of the ACT program and treatment regimen are:
> 3. To improve functioning in adult social and employment roles and activities through the provision of evidence-based employment supports;

Assessment

A comprehensive person centered needs assessment must be completed within thirty (30) days of admission to the program. The assessment includes a complete history and ongoing assessment of the following:

7. ~~Vocational~~, Educational and social interests and capacities;

Utilizing the comprehensive person centered needs assessment, an initial vocational assessment (referred to as the "career profile") in addition to member interviews, shall be completed on all individuals participating in the ACT program within thirty (30) calendar days after program entry for members admitted on or after 7/1/2023, or within ninety (90) calendar days for existing members. The career profile typically occurs over 2-3 sessions by the IPS employment specialist. The career profile will be reviewed and updated as needed at least every six (6) months or more often as appropriate to the needs of each member. Refusals to participate in and complete the career profile assessment process shall be documented within the case notes, showing efforts to engage and clinically appropriate reasons for non-completion.

Treatment Plan

A treatment plan, responsive to the member's preferences and choices must be developed and in place at the time services are rendered. The treatment plan will include input from all staff involved in treatment of the member, as well as involvement of the member and collateral others' of the member's choosing. In addition, the plan must contain the signature of the psychiatrist, the team leader involved in the treatment and the member's signature. Refusals must be documented. The treatment plan must integrate mental health and substance use services for members with co-occurring disorders. The treatment plan will be updated ~~at least~~ every three ~~six~~ (3) months or more often as needed based on the needs of each member.

Treatment plan development will include an exploration of the member's employment interests and shall be documented in the progress notes. For those individuals interested in employment, their treatment plan will include at least one vocational goal pertaining to job search, job placement, job supports, career development, career advancement.

Services

14. IPS services including ongoing exploration of employment interest, job search, job placement, job coaching, and follow-along supports.

Documentation shall be consistent with the Dartmouth Assertive Community Treatment Scale

(DACTS), ~~which is an ACT Fidelity Scale found in~~ and the SAMHSA toolkit for ACT.

Criteria for Discharge from Services

Members whose functioning has improved to the point that they no longer require the level of services and supports typically rendered by an Assertive Community Treatment team, shall begin the process to ~~should be~~ transitioned into a lower level of care. When making this determination, considerations ~~should~~ shall be made regarding the member's ability to be served within the lower level of care available to them. The ACT team should begin implementing the discharge plan and preparing the member as functioning improves to the point that they no longer require the level of services and supports.

ACT teams must formally assess member' needs for ACT services at least once every 6 months using the ACT Transition Assessment Scale, a tool that establishes criteria to help determine whether a consumer is ready to be placed on a graduation track to transition to a less intensive level of care. An individual may be placed within the graduation track if they are assessed at a one (1) or two (2) on all the scaled items. Graduations shall also be considered for individuals assessed at a one (1) or two (2) on all scaled items but assessed at a three (3) on the Activities of Daily Living item and three (3) or four (4) on the Community Integration item. Further, assess the member's Motivation to Graduate or Transition from ACT, again considering graduations for individuals assessed at a three (3) or four (4) on this item. Teams are encouraged to continually assess the service needs of participants as the member's needs change.

It is imperative that graduation be gradual, planned and individualized with assured continuity of care. More specifically, ACT teams shall employ the following strategies regarding graduations:

1. Introduce the idea of graduation from the very beginning of the member's enrollment (even during the engagement phase) and continue the discussion throughout their enrollment;
2. Frame graduation within the larger process of the member's recovery, enhanced well-being and independence in life;
3. Involve ACT team members in a discussion of the individual's potential for graduation and plans necessary to ensure successful transition to a less intensive level of care;
4. Involve the member in all plans related to his/her graduation;
5. Assess the member's motivation for transition to the graduation track and provide motivational interviewing interventions as appropriate to increase their comfort and interest in the graduation;

6. Be prepared with appropriate interventions should consumer temporarily experience an increase in symptoms or begin to "backslide" on treatment goals in response to graduation plans;
7. Involve the member's social network, including their family or support of choice, in developing and reviewing their graduation plan to the extent approved by the participant;
8. Coordinate several meetings with member, relevant ACT team members, and new service provider to introduce the new provider as well as review the participant's current status, progress in ACT and future goals;
9. Temporarily overlap ACT services with those of new provider for 30-60 days; and
10. Monitor the member's status following transition and assist the new provider, as
11. needed, especially for the next 30-60 days.

Teams shall ensure member participation in discharge activities, as evidenced by the following documentation:

1. The reasons for discharge as stated by the member and ACT team;
2. The participant's biopsychosocial status at discharge;
3. A written final evaluation summary of the member's progress toward the goals set forth in the person-centered treatment plan;
4. A plan developed in conjunction with the member for follow-up treatment after discharge; and
5. The signature of the member, their primary practitioner, the team leader and the psychiatric prescriber.

When clinically necessary, the team will make provisions for the expedited re-entry of discharged members as rapidly as possible. If immediate re-admission to the ACT team is not possible because of a full census, the provider will prioritize members who have graduated but need readmission to ACT.

Program requirements

8. Restoration of social, interpersonal relationship, and other skills needed to ensure the development of meaningful daily activities. This can occur through the provision of IPS services to support~~ing~~ work and educational efforts in addition to linking to leisure activities; and

The ACT team must:

6. Conduct ongoing monitoring and evaluation of program implementation through the collection of process and outcome measures, including the following:.

a. Process measures related to ACT programming shall be ~~should be~~ obtained through utilization of the ~~EBP Fidelity Scale and General Organizational Index as found within the SAMHSA ACT Toolkit~~ Dartmouth Assertive Community Treatment Scale (DACTS) and General Organizational Index (GOI); ~~Outcome measures such as homelessness, hospitalizations (psychiatric/medical), emergency department presentations (psychiatric/medical), incarcerations and/or arrests/detainments, substance use treatment (residential/inpatient/outpatient), utilizations of primary care physician (PCP), employment and educational status should be collected in addition to the EBP fidelity measures.~~
b. Concurrent to this process, fidelity to IPS programming shall be evaluated utilizing the Supported Employment Fidelity Scale found at https://ipsworks.org/wp-content/uploads/2017/08/IPS-Fidelity-ScaleEng1.pdf; and
c. Outcome measures shall be collected via a standardized outcomes reporting instrument which is provided by and submitted to the MCOs monthly.

The ACT program provides three levels of interaction with the participating members, including:

1. Face-to-face encounter – ACT team must provide a minimum of six (6) clinically meaningful face to face encounters with the member monthly with the majority of encounters occurring outside of the office. Encounters ~~should~~ shall address components of the member's treatment plan, involve active engagement with the member, and actively assess their functioning. Teams must document clinically appropriate reasons if this minimum number of encounters cannot be made monthly. Teams must also document reasons contacts are occurring within the office. Efforts shall be made to ensure services are provided throughout the month;

ACT teams will utilize IPS, an evidence-based supported employment model that is based upon eight basic principles that include the following:

1. Open to anyone who wants to work;
2. Focus on competitive employment;
3. Rapid job search;
4. Targeted job development;
5. Client preferences guide decisions;
6. Individualized long-term supports;

7. Integrated with treatment; and
8. Benefits counseling provided.

Each IPS Specialist carries out all phases of employment services; including completion of career profile, job search plan, job placement, job coaching, and follow-along supports before step-down from IPS into ongoing follow along provided through the ACT team through traditional service provision.

Members are not asked to complete any vocational evaluations, i.e. paper and pencil vocational tests, interest inventories, work samples, or situational assessments, or other types of assessment in order to receive assistance obtaining a competitive job.

A career profile is typically completed during 2-3 sessions, and should include information about the member's preferences, experiences, skills, strengths, personal contacts, etc. The career profile is reviewed and updated as needed with each new job experience and/or at least every six (6) months. The information may be provided by the member, treatment team, medical records, and with the member's permission, from family members, and previous employers. For new admissions, the initial career profile must be completed within thirty (30) days after admission to the ACT program.

For those individuals who have expressed an interest in employment, an individualized job search plan is developed with the member, and is updated with information from the career profile, and new job experiences. IPS specialists will visit employers systematically, based upon the member's preferences, to learn about the employer's needs and hiring preferences. Each IPS Specialist is to make at least six (6) face-to-face employer contacts per week, whether or not the member is present. IPS Specialist are to use a weekly tracking form to document their employer contacts. The first face-to-face contact with an employer by the member or the IPS Specialist shall occur within 30 days of the member entering the program.

IPS Specialists are to have a face-to-face meeting with the member within one (1) week before starting a job, within three (3) days after starting a job, weekly for the first month, and at least monthly for a year or more, on average, after working steadily, and desired by members. At this time, members are to be transitioned to step down job supports from a mental health worker following steady employment. If a need arises for more intense support by the IPS specialist, they will increase the number of interactions with the member.

IPS specialists contact members within three (3) days of learning about the job loss. IPS specialists also provide employer support (e.g., educational information, job accommodations) at a member's request.

IPS provides assistance to find another job, when one job has ended, regardless of the reason the job ended, or the number of jobs the member has had. Each job is viewed as a learning experience, and offers to help find a new job is based upon the lessons learned.

Job supports are individualized and continue for as long as the member wants and needs the support. Members receive different types of support based upon the job, member preferences, work history, and needs. The IPS Specialist may also assist the member to obtain the job accommodations necessary for the member to perform the job efficiently and effectively.

IPS Specialists ensure that members are offered comprehensive and personalized benefits planning, including information about how their work may affect their disability and government benefits, as both are based upon their income. These may include medical benefits, medication subsidies, housing subsidies, food stamps, spouse and dependent children benefits, past job retirement benefits, and other sources of income.

Service termination is not based on missed appointments or fixed time limits.

Engagement and outreach attempts made by integrated ACT team members are systematically documented, including multiple home/community visits, coordinated visits by IPS specialist with integrated ACT team member, and contacts with family, when applicable. Once it is clear that the member no longer wants to work or continue with IPS services, the IPS Specialist shall review and update the career profile as needed every six (6) months; employment shall be screened every three (3) months as the treatment plan is updated.

Provider Qualifications and Responsibilities

The provider agency must meet all qualifications as required for other outpatient and rehabilitation agencies and must maintain documentation and verification of licensure, accreditation, staff criminal background checks, TB testing, drug testing, evidence of fidelity to the model (via SAMHSA ACT EBP Toolkit) and required training for staff employed or contracted with the agency. This includes successful completion of an LDH-approved Person Centered Planning training facilitated by the MCOs. New staff must complete the training within sixty (60) days of hire. Existing staff must complete the training by 6/30/24.

Each ACT team shall have the capacity to increase and decrease contacts based upon daily knowledge of the member's clinical need, with a goal of maximizing independence. The team shall have the capacity to provide multiple contacts to persons in high need and a rapid response to early signs of relapse. The nature and intensity of ACT services are adjusted through the process of daily team meetings. IPS specialists shall participate in these meetings at least weekly.

Each ACT team shall include at least:

6. One IPS ~~employment~~ specialist, who has successfully completed the OBH approved IPS training prior to providing IPS services; at least one (1) year of specialized training or supervised experience;
8. One peer specialist, who is self-identified as being in recovery from mental illness and/or substance use disorders who has successfully completed OBH required training and recognition ~~credentialing~~ requirements as a peer specialist; and
9. One IPS supervisor who has successfully completed the LDH-approved IPS training.
    a) This shall be a .20 FTE regardless of team size;
    b) This function can be fulfilled by the Team Leader; or an individual who supervises IPS specialists working within multiple ACT teams; and
    c) At least one (1) year experience in employment services, which includes any experience where they have worked in programs where they helped people find jobs.

In light of workforce shortages subsequent to the COVID-19 public health emergency, temporary modifications of these staffing requirements can occur in the event of employee turnover. However, ACT teams shall notify the MCOs in writing in the event of loss of staff and provide them with a written Corrective Action Plan for filling the position and ensuring member services are not impacted. This shall occur within seven (7) calendar days of staff separation. When the position is filled and the CAP can be lifted, the ACT team shall provide written notification of such to the MCO. Staffing levels ~~should~~ shall increase proportional to the number of members served by the team in congruence with standards outlined within the DACTS.

ACT teams must meet national fidelity standards as ~~evidenced by~~ outline within the SAMHSA Assertive Community Treatment (ACT) Evidence-Based Practices (EBP) Toolkit.

Teams shall adhere to the following:

1. New teams:
    a. The ACT provider must notify the MCO in writing of its desire to create an additional team, including in this notification: justification for the creation of a new team and geographical location where the new team will operate.
        i. The MCO will investigate the need for an ACT team in the proposed geographic location and will inform the ACT provider in writing of the MCO's decision to approve or deny. If the MCO gives the ACT provider the approval to establish a new team, the provider will be required to follow the standard contracting/credentialing process with the MCOs in order to render services.
    b. The ACT provider must submit documentation to the MCO for contracting purposes including evidence of fidelity to the model including findings of self-evaluation using the DACTS/General Organizational Index (GOI) in addition to submitting the appropriate credentialing materials for vetting purposes and contact the MCO to ensure that all credentialing verification steps are met.
        i. The self-evaluation must reflect a minimum score of a 3.0 on the DACTS/GOI in order to be eligible to provide Medicaid funded services to members.
    c. The provider must also adhere to the following related to newly established teams:
        i. Submit monthly outcomes reporting to the MCOs via a template provided by the MCOs.
        ii. Undergo a fidelity review using the DACTS/GOI and the Supported Employment Fidelity Scale by an MCO-identified third party within six (6) months of implementation:
            1. This review must reflect a minimum score of 3.0 on the DACTS/GOI in order to maintain certification and the ability to accept new members, be eligible to provide Medicaid funded services to members, and increase staff-to member ratios;
            2. If the MCO identifies a potential Quality of Care concern based on the data from the monthly Outcome Measures report the team may be subject to corrective action. The team will implement an MCO approved corrective action plan immediately for any individual DACTS criterion that

rates a one (1) or two (2). This plan should be implemented within thirty (30) days of findings or sooner as determined necessary by the MCO to mitigate health and safety issues for members; and

3. If the fidelity review findings does not reflect a minimum overall score of 3.0 on the DACTS/GOI, the provider will forfeit any new referrals until an overall score of 3.0 is achieved. The provider will be permitted to work with existing members as long as there are no health and safety violations with operations as determined by the MCO or LDH. The team shall implement a remediation plan and undergo another fidelity review within three (3) months by the fidelity monitor. This review will be at the cost of the provider. If the team achieves an overall score of 3.0 or greater on the DACTS/GOI in the subsequent review, the team can begin accepting new referrals;
4. The Supported Employment Fidelity Scale review must reflect continued improvement toward the desired score of 100 (good fidelity); and
5. The team will implement an MCO approved corrective action plan immediately for any individual Supported Employment Fidelity Scale criterion that rates below 100 (good fidelity). This plan must be implemented within thirty (30) days of findings or sooner as determined necessary by the MCO to mitigate health and safety issues for members.

2. Existing teams:
    a. Must submit monthly outcomes reporting to MCOs via a template provided by the MCOs;
    b. Must participate in fidelity reviews using the DACTS/GOI conducted by the MCO or designee at least annually (every twelve (12) months) or more frequently as prescribed by the MCO;
    c. The team will implement an MCO approved corrective action plan immediately for any individual DACTS criterion that rates a one (1) or two (2);
    d. Must undergo a fidelity review using the Support Employment Fidelity Scale by an MCO-identified third party in conjunction with the DACTS/GOI fidelity review;

i. This review must reflect continued improvement toward the desired score of 100 (good fidelity);
ii. The team will implement an MCO approved corrective action plan immediately for any individual Supported Employment Fidelity Scale criterion that rates below 100 (good fidelity). This plan must be implemented within thirty (30) days of findings or sooner as determined necessary by the MCO to mitigate health and safety issues for members.

e. Must achieve a score 3.0 and above on the DACTS/GOI in order to maintain certification and the ability to accept new clients;
f. If a 4.2 or higher on the DACTS/GOI is achieved, the team will be deemed as operating with "exceptional practice":
    i. MCOs may grant extensions of eighteen (18) month intervals between fidelity reviews for teams operating with "exceptional practice."
g. Operating below acceptable fidelity thresholds:
    i. Teams, which achieve less than a 3.0 on the DACTS/GOI, will forfeit the ability to accept new members though they can continue to work with existing members as long as there are no health and safety violations with operations as determined by the MCO or LDH;
    ii. Teams shall implement a remediation plan and undergo another fidelity review within three (3) months by the MCO or designee. This review will be at the cost of the provider. If the team achieves an overall score of 3.0 or greater on the DACTS/GOI in the subsequent review, the team can begin accepting new referrals; and
    iii. If the team achieves more than a 3.0 on the DACTS/GOI in subsequent review, the team can begin accepting new referrals.

September 2020

Revisions made to update service criteria for Assertive Community Treatment.
Publication date: 9/14/20

Assertive Community Treatment (ACT) services are community-based therapeutic interventions that address the functional problems of members who have the most complex and/or pervasive conditions associated with serious mental illness. These interventions are strength-based and focused on supporting recovery through the restoration of functional daily living skills, building strengths, increasing independence, developing social connections and leisure opportunities, and reducing the symptoms of their illness. Through these activities, the goal is to ~~symptom stability~~ increase the member's ability to cope and

relate to others while enhancing the member's highest level of functioning in the community.

Interventions may address adaptive and recovery skill areas. These include, but are not limited to, supportive interventions to help maintain housing and employment ~~school and training opportunities~~, daily activities, health and safety, medication support, harm reduction, money management, entitlements, service planning, and coordination.

The primary goals of the ACT program and treatment regimen are:

- To lessen or eliminate the debilitating symptoms of mental illness or co-occurring addiction disorders the member experiences and to minimize or prevent recurrent acute episodes of the illness.

Target population

ACT serves members eighteen (18) years old or older who have a severe and persistent mental illness (SPMI) and members with co-occurring disorders listed in the diagnostic nomenclature (current diagnosis per DSM) that seriously impairs their functioning in the community.

Exception criteria:

- The member does not meet medical necessity criteria above, but is recommended as appropriate to receive ACT services by the ~~funding agency or designee~~ member's health plan, the ACT team leader, clinical director and psychiatrist, in order to protect public safety and promote recovery from acute symptoms related to mental illness. ~~Examples include those exiting institutions such as nursing facilities, prisons, and/or intermediate level inpatient psychiatric hospitals, or individuals with frequent incidence of emergency department (ED) presentations or involvement with crisis outreach.~~ Examples include:
  - Members discharging from institutions such as nursing facilities, prisons, and/or inpatient psychiatric hospitals,
  - Members with frequent incidence of emergency department (ED) presentations and/or involvement with crisis services,
  - Members identified as being part of the My Choice Louisiana Program target population who meet the following criteria,

excluding those members with co-occurring SMI and dementia where dementia is the primary diagnosis:

- Medicaid-eligible members over age eighteen (18) with SMI currently residing in NF or
- Members over age eighteen (18) with SMI who are referred for a Pre-Admission Screening and Resident Review (PASRR) Level II evaluation of nursing facility placement on or after June 6, 2016

Assessment

A comprehensive person centered needs assessment must be completed within thirty (30) days of admission to the program. The assessment includes a complete history and ongoing assessment of:

- Psychiatric history, status and diagnosis,
- Level of Care Utilization System (LOCUS),
- Telesage Outcomes Measurement System, as appropriate,
- Psychiatric evaluation,
- Strengths assessment,
- Housing and living situation,
- Vocational, educational and social interests and capacities,
- Self-care abilities,
- Family and social relationships,
- Family education and support needs,
- Physical health,
- Alcohol and drug use,
- Legal situation, and
- Personal and environmental resources.

Services

Service provision for ACT will be based on the assessment and a recovery focused and strengths based treatment plan. The teams will provide the following supports and services to members:

- Crisis assessment and intervention;
- Symptom management;
- Individual counseling;
- Medication administration, monitoring, education and documentation;
- Skills restoration to enable self-care and daily life management, including utilization of public transportation, maintenance of living environment, money

management, meal preparation, nutrition and health, locating and maintaining a home, skills in landlord/tenant negotiations and renter's rights and responsibilities.;

- Social and interpersonal skills rehabilitation necessary to participate in community based activities including but not limited to those necessary for functioning in a work, educational, leisure or other community environment;
- Peer support, supporting strategies for symptom/behavior management. This occurs through providing expertise about the recovery process, peer counseling to members with their families, as well as other rehabilitation and support functions as coordinated within the context of a comprehensive treatment plan.;

- Addiction treatment and education, including counseling, relapse prevention, harm reduction, anger and stress management;
- Referral and linkage or direct assistance to ensure that members obtain the basic necessities of daily life, including primary and specialty medical care, social and financial supports;
- Education, support and consultation to members' families and other major supports;
- Monitoring and follow-up to help determine if services are being delivered as set forth in the treatment plan and if the services are adequate to address the member's changing needs or status; ~~Monitoring and follow-up to help determine if psychiatric, substance use, mental health support and health related services are being delivered as set forth in the treatment plan, adequacy of services in the plan and changes, needs or status of member;~~
- Assist the member in applying for benefits. At a minimum, this includes Social Security Income, Medicaid and Patient Assistance Program enrollment; and
- For those members with forensic involvement, the team will liaise with the forensic coordinators as appropriate, further providing advocacy, education and linkage with the criminal justice system to ensure the member's needs are met in regards to their judicial involvement, and that they are compliant with the court orders.

Criteria for Discharge from Services

Members whose functioning has improved to the point that they no longer require the level of services and supports typically rendered by an Assertive Community Treatment team, should be transitioned into a lower level of care. When making this determination, considerations should be made regarding the member's ability to be served within the lower level of care available to them. The ACT team should begin implementing the discharge plan and preparing the member as functioning improves to the point that they no longer require the level of services and supports.

Program requirements

- Face-to-face encounter – ACT team must provide a minimum of six (6) clinically meaningful face to face encounters with the member monthly with the majority of encounters occurring outside of the office. Encounters should address components of the member's treatment plan, involve active engagement with the member, and actively assess their functioning. Teams must document clinically appropriate reasons if this minimum number of encounters cannot be made monthly. Teams must also document reasons contacts are occurring within the office. Efforts shall be made to ensure services are provided throughout the month. ~~At least 60 percent of all ACT team activities must be face-to-face, with approximately 90 percent of these encounters occurring outside of the office~~.

For those members transitioning from psychiatric or nursing facilities, ACT staff must provide a minimum of four encounters a week with the member during the first thirty (30) days post transition into the community. Encounters should be meaningful per the guidance outlined above. If this minimum number of encounters cannot be made, ACT staff must document clinically appropriate reasons for why this number of encounters cannot be achieved. ~~ACT staff team must provide a minimum of six encounters with the service recipient or collateral contacts monthly and must document clinically appropriate reasons if this minimum number of encounters cannot be made monthly. At least 50 percent of the encounters shall be with the service recipient. Efforts shall be made to ensure services are provided throughout the month.~~

Provider Qualifications and Responsibilities

Each ACT team shall include at least:

- One (1) ACT team leader, who is a full time LMHP who must have both administrative and clinical skills;
- One (1) prescriber, who can be either a board-certified or board-eligible psychiatrist, a medical psychologist, or an advanced practice registered nurse (APRN) with specialty in adult mental health and meeting the medical director requirements of licensure for Behavioral Health Service (BHS) providers;
  In the event a medical psychologist or APRN are utilized, the team must be able to consult with psychiatrists.
- Two (2) nurses, at least one (1) of whom shall be a RN. Both nurses must have experience in carrying out medical functioning activities such as basic health and medical assessment, education and coordination of health care, psychiatric medical assessment and treatment, and administration of psychotropic medication;
- One other LMHP; (Effective March, 2021)
- One substance use specialist, who has a minimum of one (1) year specialized substance use training or supervised experience;

- One employment specialist, who has at least one (1) year of specialized training or supervised experience;
- One housing specialist, who has at least one (1) year of specialized training or supervised experience; and
- One peer specialist, who is self-identified as being in recovery from mental illness and/or substance use disorders who has successfully completed OBH required training and credentialing requirements as a peer specialist;

Staffing levels should increase proportional to the number of members served by the team in congruence with standards outlined within the DACTS.

Effective March, 2021, ACT teams must meet national fidelity standards as evidenced by the SAMHSA Assertive Community Treatment (ACT) Evidence-Based Practices (EBP) Toolkit.

- New teams:
  - Must submit documentation to the MCO for contracting purposes including evidence of fidelity to the model including findings of self-evaluation using the DACTS/GOI.
    - The self-evaluation must reflect a minimum score of a 3.0 on the DACTS/GOI in order to be eligible to provide Medicaid funded services to members.
  - Must undergo a fidelity review using the DACTS/GOI by an MCO-identified third party within six (6) months of implementation.
    - This review must reflect a minimum score of 3.0 on the DACTS/GOI in order to maintain certification and the ability to accept new members.
    - The team will implement an MCO approved corrective action plan immediately for any individual DACTS criterion that rates a one (1) or two (2). This plan should be implemented within thirty (30) days of findings or sooner as determined necessary by the MCO to mitigate health and safety issues for members.

- Existing teams:
  - Must participate in fidelity reviews using the DACTS/GOI conducted by the MCO or designee at least annually (every twelve (12) months) or more frequently as prescribed by the MCO.
    - The team will implement an MCO approved corrective action plan immediately for any individual DACTS criterion that rates a one (1) or two (2)
    - Must achieve a score 3.0 and above on the DACTS/GOI in order to maintain certification and the ability to accept new clients
    - If a 4.2 or higher on the DACTS/GOI is achieved, the team will be deemed as operating with "exceptional practice"

- MCOs may grant extensions of eighteen (18) month intervals between fidelity reviews for teams operating with "exceptional practice".

- Operating below acceptable fidelity thresholds:
  - Teams, which achieve less than a 3.0 on the DACTS/GOI, will forfeit the ability to accept new members though they can continue to work with existing members as long as there are no health and safety violations with operations as determined by the MCO or LDH.
    - Teams shall implement a remediation plan and undergo another fidelity review within three (3) months by the MCO or designee.
      - If the team achieves more than a 3.0 on the DACTS/GOI in subsequent review, the team can begin accepting new referrals.

Additional Service Criteria

ACT agencies must adhere to requirements established in the Outpatient Services: Rehabilitation Services chapter of this manual. Please refer to that section for specific information on provider responsibilities.

Billing

~~Only direct staff face-to-face time with the member or family may be billed. ACT may be billed for under CPST but must be consistent with the CPST State Plan definition. CPST is a face-to-face intervention with the individual present; however, family or other collaterals may also be involved. Medicaid also does not pay when the vocational supports provided via ACT qualify for vocational rehabilitation funding, even if the vocational rehabilitation services are not available.~~

NOTE: Individualized substance use treatment will be provided to those members for whom this is appropriate; co-occurring disorder treatment groups will also be provided off-site of the ACT administrative offices, though they do not take the place of individualized treatment. ~~Substance use/mental health treatment will also include dialectical behavioral therapy, cognitive behavioral therapy (CBT) and motivational enhancement therapy~~.

The following activities may not be billed or considered the activity for which the ACT per diem is billed:

- Time spent doing, attending, or participating in recreational activities.
- Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide or an academic tutor.

- Habilitative services for the adult to acquire, retain, and improve the self-help, socialization and adaptive skills necessary to reside successfully in community settings.
- Child care services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
- Respite care.
- Transportation for the individual or family. Services provided in the car are considered transportation.
- Services provided under age 18.
- Covered services that have not been rendered.
- Services provided before approved authorization.
- Services rendered that are not in accordance with an approved authorization.
- Services not identified on the authorized treatment plan.
- Services provided without prior authorization.
- Services provided to the children, spouse, parents, or siblings of the eligible adult under treatment or others in the eligible member's life to address problems not directly related to the eligible member's issues and not listed on the eligible member's treatment plan.
- Services provided that are not within the provider's scope of practice.
- Any art, movement, dance or drama therapies.

- Anything not included in the approved ACT services description.

June 2019

Clarified language regarding Target Populations and Program Requirements.
Publication date: 6/12/19

Target population

Exception criteria:

- The individual does not meet medical necessity criteria above ~~I or II~~, but is recommended as appropriate to receive ACT services by the funding agency or designee, the ACT team leader, clinical director and psychiatrist, in order to protect public safety and promote recovery from acute symptoms related to mental illness. Examples include those exiting institutions such as nursing facilities, prisons, and/or intermediate level inpatient psychiatric hospitals, or individuals with frequent incidence of emergency department (ED) presentations or involvement with crisis outreach.

Program requirements

- ACT team must conduct ongoing monitoring and evaluation of program implementation through the collection of process and outcome measures. Process

measures should be obtained through utilization of the EBP Fidelity Scale and General Organizational Index as found within the SAMHSA ACT Toolkit. Outcome measures such as homelessness, hospitalizations (psychiatric/medical), emergency department presentations (psychiatric/medical), incarcerations or arrests/detainments, substance use treatment (residential/inpatient), utilizations of primary care physician (PCP), employment and educational status should be collected in addition to the EBP fidelity measures.

Billing

~~Intensive case management (ICM) may be billed using a combination of codes licensed practitioner, PSR and CPST, subject to prior authorization. ICM is not an EBP and use of research based and evidence based practices is preferred over the use of ICM.~~

June 2018

Revised to update provider qualifications and responsibilities to ensure compliance with current licensing requirements.

Publication date: 6/1/18

Effective in accordance with the licensing rule

Provider Qualifications and Responsibilities

The MCO may contract with ACT teams meeting national fidelity standards as evidenced by the SAMHSA Assertive Community Treatment (ACT) Evidence-Based Practices (EBP) Toolkit.

ACT agencies must be licensed ~~in accordance with~~ pursuant to La. R.S. 40:2151, et. seq. for behavioral health service providers and accredited by an LDH approved national accrediting body: Commission on Accreditation of Rehabilitation Facilities (CARF), Council on Accreditation (COA) or The Joint Commission (TJC). Denial, loss of, or any negative change in accreditation status must be reported in writing immediately upon notification by the accrediting body of such denial, loss of, or any negative change in accreditation status to ~~their contracted MCOs in writing immediately upon notification by the accreditation body~~ the managed care entities with which the ACT agency contracts or is reimbursed.

NOTE: Effective March 14, 2017, ACT agencies must apply for accreditation and pay accreditation fees prior to being contracted with or reimbursed by a Medicaid managed care entity, and must maintain proof of accreditation application and fee payment. ACT agencies must attain full accreditation within 18 months of the initial accreditation application date. ACT Agencies contracted with a managed care entity prior to March 14, 2017, must attain full accreditation by September 14, 2018, i.e. 18 months from the initial effective date of the requirement for ACT agencies.

The provider agency must meet all qualifications as required for other outpatient and rehabilitation agencies and must maintain documentation and verification of licensure, accreditation, staff criminal background checks, TB testing, drug testing, evidence of fidelity to the model (via SAMHSA ACT EBP Toolkit) and required training for staff employed or contracted with the agency.

ACT agencies must adhere to all requirements established in the Provider Responsibilities section located in the Outpatient Services: Rehabilitation Services chapter of this manual. Please refer to that section for specific information on all provider responsibilities.

Revision Details to Appendix E-2 Evidence Based Practices Functional Family Therapy/Functional Family Therapy – Child Welfare (FFT/FFT-CW) of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

June 2018
Revised to update provider qualifications and responsibilities to ensure compliance with current licensing requirements.
Publication date: 6/1/18
Effective in accordance with the licensing rule

Provider Qualifications and Responsibilities
FFT/FFT-CW agencies must adhere to all requirements established in the Provider Responsibilities section located in the Outpatient Services: Rehabilitation Services chapter of this manual.

EXCEPTIONS:

1. BHSPs ***exclusively*** providing the evidence-based practice Functional Family Therapy (FFT/FFTCW), Homebuilders® or Multi-Systemic Therapy (MST) are excluded from the requirement to provide **medication management.** Such BHSPs shall develop policies and procedures to ensure:
    (a) screening of clients for medication management needs;
    (b) referral to appropriate community providers for medication management including assistance to the client/family to secure services; and
    (c) collaboration with the client's medication management provider as needed for coordination of the client's care.
2. BHSPs ***exclusively*** providing the evidence-based practice Functional Family Therapy (FFT/FFTCW), Homebuilders® or Multi-Systemic Therapy (MST) are excluded from the requirement of having a **Medical Director**. Such BHSPs shall have a **Clinical Director** in accordance with Core Staffing 2. a. – c. of the Outpatient Services: Rehabilitation Services chapter of this manual.

Exclusions

~~FFT/FFTCW services are comprehensive of all other services, with the exception of psychological evaluation n or assessment and medication management. These may be provided and billed separately for a recipient receiving FFT services.~~

~~FFT shall not be billed in conjunction with the following services:~~

- ~~BH services by licensed and unlicensed individuals, other than medication management and assessment.~~
- ~~Residential services, including professional resource family care.~~

FFT shall not be billed in conjunction with PRTF services:

As standard practice, FFT/FFTCW may be billed with medication management and assessment. FFT may also be billed in conjunction with another behavioral health service (such as individual therapy, CPST, PSR, or ILSB) if:

- The youth has a high level of need such that a combination of both family-focused and individually-focused services is needed to meet the youth's required level of treatment intensity;
- There is a clear treatment plan or Plan of Care indicating distinct goals or objectives being addressed by both the FFT/FFTCW service and by the concurrent service; and
- The services are delivered in coordination of each other to ensure no overlap or contradiction in treatment.

Revision Details to Appendix E-3 Evidence Based Practices - HOMEBUILDERS® (HB)of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

June 2018

Revised to update provider qualifications and responsibilities to ensure compliance with current licensing requirements.
Publication date: 6/1/18
Effective in accordance with the licensing rule

Provider Qualifications and Responsibilities
Homebuilders® agencies must adhere to all requirements established in the Provider Responsibilities section located in the Outpatient Services: Rehabilitation Services chapter of this manual.

EXCEPTIONS:

1. BHSPs ***exclusively*** providing the evidence-based practice Functional Family Therapy (FFT/FFTCW), Homebuilders® or Multi-Systemic Therapy (MST) are excluded from the requirement to provide **medication management.** Such BHSPs shall develop policies and procedures to ensure:
    (a) screening of clients for medication management needs;
    (b) referral to appropriate community providers for medication management including assistance to the client/family to secure services; and
    (c) collaboration with the client's medication management provider as needed for coordination of the client's care.
2. BHSPs ***exclusively*** providing the evidence-based practice Functional Family Therapy (FFT/FFTCW), Homebuilders® or Multi-Systemic Therapy (MST) are excluded from the requirement of having a **Medical Director**. Such BHSPs shall have a **Clinical Director** in accordance with Core Staffing 2. a. – c. of the Outpatient Services: Rehabilitation Services chapter of this manual.

Revision Details to Appendix E-4 Evidence Based Practices Multi-Systemic Therapy (MST)of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

February 2021

Revisions made to update treatment plan expectations and supervision.

Publication date: 2/5/21

Treatment Planning

All treatment planning will be informed by an initial psychosocial assessment, which is completed by the MST Supervisor prior to entry into MST services. Use of the Child and Adolescent Level of Care Utilization System (CALOCUS) is not required for MST.

In the MST model, the MST therapist conducts treatment planning using the MST "Case Summary" process; for a member receiving MST services, the document titled "Initial Case Summary," and the documents which are updated each week as the "Weekly Case Summary," serve as the treatment plan for the member. The Initial Case Summary ~~treatment plan~~ is developed by the MST therapist, based on the assessment, youth and family strengths, ~~based on the~~ referral behaviors, and the goals of the youth and family. Goals of the youth, family, and other key participants in treatment (i.e., probation officer) are documented in the Case Summary as "Desired Outcomes of Key Participants," and these inform the "Overarching Goals" of treatment as documented in the Case Summary.

The Initial Case Summary is signed by the caregiver, and ideally signed by the youth as well. In the rare event that an MST treatment episode extended for over 180 days, the MST provider must obtain additional caregiver and youth signatures on the updated Case Summary at that time.

The Initial Case Summary is then continuously updated in the Weekly Case Summaries. ~~includes~~ Weekly Case Summaries are driven by continuous assessment, data collection and analysis, ~~documentation~~, team and supervisory input, goal development, intervention development and implementation, outcome assessment, and ongoing plan revision ~~and~~

~~termination~~. Overarching goals are established at the beginning of treatment, while specific objectives are updated each week and closely monitored in the Weekly Case Summaries. In each Weekly Case Summary, the MST therapist reviews the Overarching Goals, and then:

- Develops Intermediary Goals that are specific, measureable action-oriented, realistic, and time-limited objectives,
- Outlines intervention steps that will be taken to accomplish each Intermediary Goal
- Reviews previous Intermediary Goals, and
- Documents advances in treatment, to indicate progress being made, and ongoing assessment of barriers, which leads to development of new intermediary goals.

MST provides LMHP oversight over treatment planning through MST supervision and consultation, which includes weekly review of treatment planning between the MST clinician, MST supervisor, and MST consultant. Supervisor and consultant feedback will be integrated into the Weekly Case Summaries and will be implemented into the upcoming week's intervention plan.

Supervision

Weekly group supervision and consultation is documented on the MST Weekly Case Summaries, which document a weekly review of work on the case (goals, barriers, advances in treatment, ongoing assessment, and new goals) along with questions for supervision and consultation, and feedback received by the MST therapist from supervision and consultation.

Individual supervision of MST clinicians is not a requirement for an MST license through MST Services; within the MST model, group supervision is the preferred modality. However, effective July 15, 2020, all non-licensed providers of rehabilitation services under LA Medicaid (inclusive of non-licensed MST clinicians) are required to have **no less than one (1) hour of individual supervision,** as part of the overall requirement for a minimum of 4 hours of clinical supervision per month for non-licensed staff.

June 2018

Revised to update provider qualifications and responsibilities to ensure compliance with current licensing requirements.

Publication date: 6/1/18

Effective in accordance with the licensing rule

Provider Qualifications and Responsibilities

MST agencies must adhere to all requirements established in the Provider Responsibilities section located in the Outpatient Services: Rehabilitation Services chapter of this manual.

EXCEPTIONS:

1. BHSPs ***exclusively*** providing the evidence-based practice Functional Family Therapy (FFT/FFTCW), Homebuilders® or Multi-Systemic Therapy (MST) are excluded from the requirement to provide **medication management.** Such BHSPs shall develop policies and procedures to ensure:
    (a) screening of clients for medication management needs;
    (b) referral to appropriate community providers for medication management including assistance to the client/family to secure services; and
    (c) collaboration with the client's medication management provider as needed for coordination of the client's care.
2. BHSPs ***exclusively*** providing the evidence-based practice Functional Family Therapy (FFT/FFTCW), Homebuilders® or Multi-Systemic Therapy (MST) are excluded from the requirement of having a **Medical Director**. Such BHSPs shall have a **Clinical Director** in accordance with Core Staffing 2. a. – c. of the Outpatient Services: Rehabilitation Services chapter of this manual.

Revision Details to Appendix E-5 Evidenced Based Practices– Child/Parent Psychotherapy of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

July 2019

Clarification of billing code identifier on page 7.
Publication date: 7/1619

June 2019

New appendix added to the manual.
Publication date: 6/12/19

Revision Details to Appendix E-6 Evidenced Based Practices – Parent-Child Interaction Therapy of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

July 2019

Clarification of billing code identifier on page 7.
Publication date: 7/1619

June 2019

New appendix added to the manual.
Publication date: 6/12/19

Revision Details to Appendix E-7 Evidenced Based Practices – Preschool PTSD Treatment and Youth PTSD of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

July 2019

Clarification of billing code identifier on page 7.
Publication date: 7/1619

June 2019

New appendix added to the manual.
Publication date: 6/12/19

Revision Details to Appendix E-8 Evidenced Based Practices – Triple P Positive Parenting Program – Standard Level 4 of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

April 2020

New appendix added to the manual.
Publication date: 4/22/20

Revision Details to Appendix E-9 Evidenced Based Practices – Trauma-Focused Cognitive Behavioral Therapy of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

April 2020

New appendix added to the manual.
Publication date: 4/22/20

Revision Details to Appendix E-10 Evidence Based Practices – EMDR Therapy of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

June 2020

New appendix added to the manual.
Publication date: 6/30/20

Revision Details to Appendix E-11 Evidence Based Practices –DBT of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

October 2023

New appendix added to the manual.
Publication date: 10/31/23

Revision Details to Appendix F CSoC Wraparound Model of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

February 2024

Revisions to update WAA Qualifications Requirements and Wraparound Facilitator criteria.
Publication date: 2/26/24

WAA Qualification Requirements
~~Arranges for and maintains documentation that all persons, prior to employment, are free from tuberculosis (TB) in a communicable state via skin testing to reduce the risk of such infections in members and staff. Results from testing performed over 30 days prior to date of employment will not be accepted as meeting this requirement;~~

WAA Staff Qualification Requirements
~~Pass a TB test;~~

Wraparound Facilitator
The Wraparound facilitator must meet the following requirements: 1. Bachelor's-level degree in a human services field or bachelor's-level degree in any field, with a minimum of two (2) years of full-time experience working in relevant family, children/youth or community service capacity. Relevant experience shall include working with the target population; experience in navigating any of the child/family-serving systems; and experience advocating for family members who are involved with behavioral health systems. Relevant alternative experience may substitute for the bachelor's-level degree requirement in individual cases, subject to approval by LDH; and

Requirements include the following:
1. Master's-level or higher graduate degree in a human services field (see Appendix B of this manual chapter);
2. Master's level or higher graduate degree in any field, with a minimum of three years of full-time experience working in relevant family, children/youth or community service capacity. Relevant experience shall include working with the target population; experience in navigating any of the child/family-serving systems; and experience advocating for family members who are involved with behavioral health systems. Relevant alternative experience may substitute for the degree requirement in individual cases, subject to approval by LDH;

6. The WF supervisor/coach must have expertise, knowledge and skills in the Wraparound model and possess the ability to teach and develop those skills in the Wraparound facilitator. Previous wraparound experience is preferred. A Wraparound supervisor/coach must have a high degree of cultural awareness and the ability to engage families from different cultures, and backgrounds. A preferred supervisor/coach characteristic is an understanding of, and experience with, different systems, including schools, behavioral health, child welfare, juvenile justice, health and others. The WF supervisor/coach must oversee the work of the WF on an ongoing basis.

Observation of Wraparound Facilitators by Supervisor/Coach
Three ~~meeting~~s observations within the first six months of hire (two CFT meetings; One – supervisor's choice); and

November 2023

Revisions made to update criteria throughout section.
Publication date: 11/13/23

Conflicts of Interest
NOTE: This language does not preclude the parent agency of a WAA, from providing regionally-based crisis response services, under a separate behavioral health services provider license, enrolled and credentialed as a separate entity.

January 2021

Revisions made to clarify Wraparound Agency and staff qualification requirements.
Publication date: 1/5/21

WAA Qualification Requirements
• Arranges for and maintains documentation that all persons, prior to employment, pass criminal background checks ~~through the Louisiana Department of Public Safety, State Police~~ and a search of the U.S. Department of Justice National Sex Offender Registry. If the results of any criminal background check reveal that the potential employee (or contractor) was convicted of any offenses against a child/youth or an elderly or disabled person, the WAA provider shall not hire and/or shall terminate the employment (or contract) of such individual. The WAA provider shall not hire an individual with a record as a sex offender nor permit these individuals to work for the provider as a subcontractor. Criminal background accordance with La. R.S. 15:587 et seq. ~~Criminal background checks performed over 30 days prior to date of employment will not be accepted as meeting this requirement.~~
• The WAA shall not hire individuals failing to meet criminal background check requirements and regulations. Individuals not in compliance with criminal background check requirements and regulations shall not be utilized on an employment, contract nor

volunteer basis. Criminal background checks performed over 30 days prior to the date of employment will not be accepted as meeting the criminal background check requirement. The WAA provider shall maintain the results of an individual's criminal background check in the individual's personnel record and comply with the confidentiality requirements of La. R.S. 40:1203.4.

• The WAA must review the Department of Health and Human Services' Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) and the LDH State Adverse Actions website prior to hiring or contracting any employee or contractor that performs services that are compensated with Medicaid/Medicare funds, including but not limited to licensed and unlicensed staff, interns and contractors. Once employed, the lists must be checked once a month thereafter to determine if there is a finding that an employee or contractor has abused, neglected or extorted any individual or if they have been excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General. The OIG maintains the LEIE on the OIG website (https://exclusions.oig.hhs.gov) and the LDH Adverse Action website is located at https://adverseactions.ldh.la.gov/SelSearch.
• The WAA is prohibited from knowingly employing or contracting with, or retaining the employment of or contract with, anyone who has a negative finding placed on the Louisiana State Adverse Action List, or who have been excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General. The WAA provider shall maintain the results of completed searches in the LEIE and LDH State Adverse Action databases in the individual's personnel record.

WAA Staff Qualification Requirements

• Satisfactory completion of criminal background check pursuant to La. R.S. 40:1203.1 *et seq*., La R.S. 15:587 (as applicable), and any applicable state or federal law or regulation; ~~A criminal background check through the Louisiana Department of Public Safety, State Police and a search of the U.S. Department of Justice National Sex Offender Registry will be conducted prior to employment to ensure that the potential employee (or contractor) has not been convicted of any offenses against a child/youth or an elderly or disabled person and does not have a record as a sex offender. If the results of any criminal background check reveal that the potential employee (or contractor) was convicted of any offenses against a child/youth or an elderly or disabled person, the provider shall not hire and/or shall terminate the employment (or contract) of such individual. The provider shall not hire an individual with a record as a sex offender nor permit these individuals to work for the provider as a subcontractor. Criminal background checks must be performed as required by R.S. 40:1203 et seq., and in accordance with R.S. 15:587 et seq.;~~

• Employees and contractors must not be excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General;
• Staff must not have a finding on the Louisiana State Adverse Action List;
• ~~Pass a motor vehicle screen;~~
• Pass a TB test;
• Pass drug screening tests as required by WAA provider's ~~agency's~~ policies and procedures; and

• Complete AHA recognized First Aid, CPR and seizure assessment training. (Note: psychiatrists, APRNs/~~CNSs/~~PAs, registered nurses (RNs) and licensed practical nurses (LPNs) are exempt from this training.)

July 2018

Revised to remove the fingerprinting specifications on pages 12 and 14.
Publication date: 7/20/18
Effective date: October 6, 2017

Revision Details to Appendix G - Standardized Assessments for Members Receiving CPST and PSR of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

March 2018

New appendix added to the manual.
Publication date: 3/1/18

'Revision Details to Appendix G-2 – Supported Employment of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

January 2023

New appendix added to the manual.
Publication date: 1/1/23