Louisiana Medicaid Supplemental Clinical Criteria

Policy Number: BH803LA012024
Effective Date: January 01, 2024
Annual Review Date: May, 2024

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Introduction & Instructions for Use

Introduction

The following State or Contract Specific Clinical Criteria defined by state regulations or contractual requirements are used to make medical necessity determinations, mandated for members of behavioral health plans managed by Optum and U.S. Behavioral Health Plan, California (doing business as Optum Health Behavioral Solutions of California ("Optum-CA")).

Other Clinical Criteria may apply when making behavioral health medical necessity determinations for members of behavioral health plans managed by Optum®. These may be externally developed by independent third parties used in conjunction with or in place of these Clinical Criteria when required, or when state or contractual requirements are absent for certain covered services.

Instructions for Use

When deciding coverage, the member's specific benefits must be referenced. All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member's benefits prior to using these Clinical Criteria. In the event that the requested service or procedure is

limited or excluded from the benefit, is defined differently or there is otherwise a conflict between this Clinical Criteria and the member's specific benefit, the member's specific benefit supersedes these Clinical Criteria.

These Clinical Criteria are provided for informational purposes and do not constitute medical advice.

Assertive Community Treatment (ACT)

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 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, daily activities, health and safety, medication support, harm reduction, money management, entitlements, service planning, and coordination.

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:

- 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;
- To meet basic needs and enhance quality of life;
- To improve functioning in adult social and employment roles and activities through the provision of evidence-based employment supports;
- To increase community tenure; and
- To lessen the family's burden of providing care and support healthy family relationships.

Fundamental principles of this program are:

- The ACT team is the primary provider of services and, as such, functions as the fixed point of responsibility for the member;
- Services are provided in the community; and
- The services are person-centered and individualized to each member.

Admission Criteria

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.

- The member is diagnosed with one or more of the following Serious and Persistent Mental Illness (SPMI) diagnoses listed in the diagnostic nomenclature (current diagnosis per DSM) that seriously impairs their functioning in the community.
  - Schizophrenia
  - Other psychotic disorder
  - Bipolar disorder
  - Major depressive disorder

- These may also be accompanied by any of the following:
  - Substance use disorder; or
  - Developmental disability
- The member meets one or more of the following service needs:
  - Two (2) or more acute psychiatric hospitalization and/or four (4) or more emergency room visits in the last six (6) months.
  - Persistent and severe symptoms of a psychiatric disability that interferes with the ability to function in daily life.
  - Two (2) or more interactions with law enforcement in the past year for emergency services due to mental illness or substance use (this includes involuntary commitment.
  - Currently residing in an inpatient bed, but clinically assessed to be able to live in a more independent situation if intensive services were provided.
  - One or more incarcerations in the past year related to mental illness and/or substance use (Forensic Assertive Community Treatment [FACT]).
  - Psychiatric and judicial determination that FACT services are necessary to facilitate release from a forensic hospitalization or pre-trial to a lesser restrictive setting (FACT);or
  - Recommendations by probation and parole, or a judge with a FACT screening interview, indicating services are necessary to prevent probation/parole violation (FACT).
- The member must have 1 of the following:
  - Inability to participate or remain engaged or respond to traditional community-based services.
  - Inability to meet basic survival needs, or residing in substandard housing, homeless or at imminent risk of becoming homeless.
  - Services are necessary for diversion from forensic hospitalization, pretrial release or as a condition of probation to a lesser restrictive setting (FACT).
- AND
- The member must have 3 of the following:
  - Evidence of co-existing mental illness and substance use disorder.
  - Significant suicidal ideation, with a plan and ability to carry out within the last two (2) years.
  - Suicide attempt in the last two (2) years.
  - History of violence due to untreated mental illness/substance use within the last two (2) years.
  - Lack of support systems.
  - History of inadequate follow-through with treatment plan, resulting in psychiatric or medical instability.
  - Threats of harm to others in the past two (2) years.
  - History of significant psychotic symptomatology, such as command hallucinations to harm others; or
  - Minimum LOCUS score of three (3) at admission.

Exception Criteria:

- The member does not meet medical necessity criteria above but is recommended as appropriate to receive ACT services by the 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:
  - Members discharging from institutions such as nursing facilities, prisons, and/or inpatient psychiatric hospitals;
  - Members with frequent incidence of emergency department (ED) presentations or involvement with crisis services; and
  - 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.

Continuing Stay Criteria

- Service provision is based on a comprehensive person-centered needs assessment must be completed within 30 days of admission. These will include:
  - 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
  - Personal and environmental resources
- 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 07/01/2023, or within ninety (90) calendar days for existing members. The career profile typically occurs over 2-3 sessions by the IPS employment specialist.
- 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.
- The LOCUS and psychiatric evaluation will be updated at least every six (6) months or as needed based on the needs of each member, with an additional LOCUS score being completed prior to discharge.
- For members participating in FACT, the assessment will include items related to court orders, identified within thirty (30) days of admission and updated every ninety (90) days or as new court orders are received.

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 of 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 3 months or more often as needed based on the needs of each member.
- For members participating in FACT, the treatment plan will include items relevant for any specialized interventions, such as linkages with the forensic system for members involved in the judicial system.
- 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.

- A tracking system is expected of each ACT team for services and time rendered for or on behalf of any member. The treatment plan must consist of the following:
  - Plans to address all psychiatric conditions.
  - The member's treatment goals and objectives (including target dates), preferred treatment approaches and related services.
  - The member's educational, vocational, social, wellness management, and residential or recreational goals, associated concrete and measurable objectives and related services.
  - The member's goals and plans, and concrete and measurable objectives necessary for a person to get and keep their housing; and
  - A crisis/relapse prevention plan, including an advance directive.
- When psycho-pharmacological treatment is used, a specific service plan, including identification of target symptoms, medication, doses and strategies to monitor and promote commitment to medication must be used.

Discharge Criteria

- 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 be transitioned into a lower level of care. When making this determination, considerations 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 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:
  - 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;
  - Frame graduation within the larger process of the member's recovery, enhanced well-being and independence in life;
  - 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;
  - Involve the member in all plans related to his/her graduation;
  - 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;
  - 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;
  - 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;
  - 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;
  - Temporarily overlap ACT services with those of new provider for 30-60 days; and

- Monitor the member's status following transition and assist the new provider, as needed, especially for the next 30-60 days.

- Teams shall ensure member participation in discharge activities, as evidenced by the following documentation:
  - The reasons for discharge as stated by the member and ACT team;
  - The participant's biopsychosocial status at discharge;
  - A written final evaluation summary of the member's progress toward the goals set forth in the person-centered treatment plan;
  - A plan developed in conjunction with the member for follow-up treatment after discharge; and
  - 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.

Service Delivery

- 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;
  - 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 regard to their judicial involvement, and that they are compliant with the court orders; and
  - 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 the SAMHSA toolkit for ACT.

Program Requirements

- ACT services must be provided by an interdisciplinary team capable of providing the following:
  - Service coordination;
  - Crisis assessment and intervention;
  - Symptom assessment and management;
  - Individual counseling and psychotherapy;
  - Medication prescription, administration, monitoring and documentation;
  - Substance use treatment;
  - Rehabilitation services to restore capacity to manage activities of daily living;
  - 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 supporting work and educational efforts in addition to linking to leisure activities; and
  - Direct assistance to ensure that members obtain supportive housing, as needed.

- ACT is a medical psychosocial intervention program provided on the basis of the following principles:
  - The service is available twenty-four (24) hours a day, seven (7) days a week;
  - An individualized treatment plan and supports are developed;
  - At least ninety (90) percent of services are delivered as community-based outreach services;
  - An array of services are provided based on the member's medical need;
  - The service is member-directed; and
  - The service is recovery-oriented.

- The ACT team must:
  - Operate a continuous after-hours on-call system with staff that is experienced in the program and skilled in crisis intervention (CI) procedures. The ACT team must have the capacity to respond rapidly to emergencies, both in person and by telephone.
  - Provide mobilized CI in various environments, such as the member’s home, schools, jails, homeless shelters, streets and other locations.
  - Arrange or assist members to make a housing application, meet their housing obligations and gain the skills necessary to maintain their home.
  - Be involved in psychiatric hospital admissions and discharges and actively collaborate with inpatient treatment staff.
  - Ensure provision of culturally competent services.
  - ACT team must conduct ongoing monitoring and evaluation of program implementation through the collection of process and outcome measures, including the following:
    - Process measures related to ACT programming shall be obtained through utilization of the Dartmouth Assertive Community Treatment Scale (DACTS) and General Organizational Index (GOI);
    - 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-Scale-Eng1.pdf; and
    - 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:
  - Face-to-face encounter - ACT staff must be providing a minimum of six (6) clinically meaningful face to face encounters with the member monthly with the majority of encounters outside of the office. Encounters 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;

- Collateral encounter - Collateral refers to members of the member's family or household or significant others (e.g., landlord or property manager, criminal justice staff and employer) who regularly interact with the member and are directly affected by, or have the capability of affecting, his or her condition and are identified in the treatment plan as having a role in treatment. A collateral contact does not include contacts with other mental health service providers or individuals who are providing a paid service that would ordinarily be provided by the ACT team (e.g., meeting with a shelter staff person who is assisting an ACT member in locating housing); and
- Assertive outreach - Refers to the ACT team being 'assertive' about knowing what is going on with a member and acting quickly and decisively when action is called for, while increasing member independence. The team must closely monitor the relationships that the member has within the community and intervene early if difficulty arises.

- 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.
- The teams will provide comprehensive, individualized services, in an integrated, continuous fashion, through a collaborative relationship with the member. The ACT program utilizes a treatment model that is non-confrontational, follows behavioral principles, considers interactions of mental illness and substance use and has gradual expectations for abstinence.

Individual Placement and Support (IPS)

- ACT teams will utilize IPS, an evidence-based supported employment model that is based upon eight basic principles that include the following:
  - Open to anyone who wants to work;
  - Focus on competitive employment;
  - Rapid job search;
  - Targeted job development;
  - Client preferences guide decisions;
  - Individualized long-term supports;
  - Integrated with treatment; and
  - 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

- ACT agencies must be licensed 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 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 eighteen (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., eighteen (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. -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.

- 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.
- Each ACT team shall have sufficient numbers of staff to provide treatment, rehabilitation and support services twenty-four (24) hours a day, seven (7) days per week. Each ACT team shall have the capacity to provide the frequency and duration of staff-to-program member contact required by each member's treatment plan.
- 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 have a staff-to-member ratio that does not exceed 1:10. Any ACT team vacancies that occur will be filled in a timely manner to ensure that these ratios are maintained. All professional staff must be currently and appropriately licensed by the applicable professional board. Prior to providing the service, each staff member receives training on the skills and competencies necessary to provide ACT services. Each staff member must meet the required skills and competencies within six months of their employment on an ACT team. Successful completion of LOH-approved trainings can satisfy this requirement.
- 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;
  - Note: 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;
  - One substance use specialist, who has a minimum of one (1) year specialized substance use training or supervised experience;
  - One IPS employment specialist, who has successfully completed the OBH- approved IPS training prior to providing IPS services; at least one (I) year of specialized training or supervised experience;
  - One housing specialist, who has at least one (I) 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 recognition credentialing requirements as a peer specialist; and
  - One IPS supervisor who has successfully completed the LOH-approved IPS training:
    - This shall be a .20 FTE regardless of team size;
    - This function can be fulfilled by the Team Leader; or an individual who supervises IPS specialists working within multiple ACT teams; and
    - 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 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 outlined within the SAMHSA Assertive Community Treatment (ACT) Evidence-Based Practices (EBP) Toolkit.
- Teams shall adhere to the following:
  - New teams:
  - 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.
    - 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.
  - 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 (GOl) in addition to submitting the appropriate credentialing materials for vetting purposes and contact the MCO to ensure that all credentialing verification steps are met.
    - 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.
  - The provider must also adhere to the following related to newly established teams:
    - Submit monthly outcomes reporting to the MCOs via a template provided by the MCOs.
    - 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:
      - 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;
      - 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
      - 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;
      - The Supported Employment Fidelity Scale review must reflect continued improvement toward the desired score of 100 (good fidelity); and
      - 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.

- Existing teams:
  - Must submit monthly outcomes reporting to MCOs via a template provided by the MCOs;
  - 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 undergo a fidelity review using the Support Employment Fidelity Scale by an MCO-identified third party in conjunction with the DACTS/GOI fidelity review;
    - This review must reflect continued improvement toward the desired score of 100 (good fidelity);
    - 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.
  - 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. 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
    - If the team achieves more than a 3.0 on the DACTS/GOI in subsequent review, the team can begin accepting new referrals.

Exclusions

- ACT services are comprehensive of all other services, with the exception of psychological evaluation or assessment and medication management. These may be provided and billed separately for a member receiving ACT services.
- ACT shall not be billed in conjunction with the following services:
  - Behavioral health services by licensed and unlicensed individuals, other than medication management and assessment;
  - Residential services, including professional resource family care.

Rehabilitation Services for Children, Adolescents and Adults

The following provisions apply to all rehabilitation services for children, adolescents and adults,
which include the following services:

- Community Psychiatric Support and Treatment;
- Psychosocial Rehabilitation; and
- Crisis Intervention.

Community Psychiatric Support Treatment (CPST) ~~are mental health rehabilitation services designed to reduce disability from mental illness, restore functional skills of daily living, natural supports and achieve identified person-centered goals or objectives through counseling, clinical psycho-educations, and ongoing monitoring needs as set forth in the individualized treatment plan.~~

Community Psychiatric Support and Treatment (CPST) is a goal-directed support and solution focused intervention, which focuses on reducing the disability resulting from mental illness, restoring functional skills of daily living, building natural supports, and 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[i] intervention with the individual present; however, family or other collaterals also may be involved. Most contacts must 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.

- CPST may include the following components:
  - Components performed by an LMHP:
    - Initial and annual assessment, including the LOCUS/CALOCUS.
    - 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.
  - Components performed by an LMHP or other qualified professional as defined in staff qualifications
    - Ongoing monitoring of needs including triggering an update of the treatment plan by the LMHP if needs change significantly.
    - 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 evidence-based practices/strategies is encouraged.
    - 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 to work together to support recover, including assisting the individual and family members or other collaterals with identifying a potential psychiatric or personal crisis.
- CPST Provider Types
  - ~~By redesigning the CPST service to offer counseling, the list of clinical practitioners that can deliver CPST will expand to the following:~~ **Individuals rendering all other components of CPST must be the following:**
    - Licensed mental health professionals (LMHP)
    - Provisionally Licensed Professional Counselor (PLPC)
    - Provisionally Licensed Marriage And Family Therapist (PLMFT)
    - Licensed Master Social Worker (LMSW)

- Certified Social Worker (CSW)
- Psychology intern from an American Psychological Association approved internship program.

~~o Including counseling as a component of CPST as a beneficial clinical element to the services received by individuals diagnosed with serious mental illness which is part of the eligibility criteria to receive the service.~~

~~o All providers of CPST will be licensed, provisionally licensed or certified by their appropriate professional licensure board. The relevant licensure boards include the Louisiana State board of Licensed Professional Counselors and the Louisiana State Board Of Social Work Examiners.~~

~~o 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 and in accordance with the agency's accrediting body.~~

Telehealth (effective 05/01/2023)

- 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. Except for the service area restrictions of licensed behavioral health services providers in accordance with LAC. Tit. 48.I. 5605 M., or current applicable regulations, 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; and
  - 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.

Psychosocial Rehabilitation

Psychosocial rehabilitation (PSR) services are designed to assist the individual with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their mental illness. Activities included must be intended to achieve the identified goals or objectives as set forth in the individual's individualized treatment plan. The intent of PSR is 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. PSR is a face-to-face intervention with the individual present. Services may be provided

individually or in a group setting. Most contacts occur in community locations where the person lives, works, attends school and/or socializes. PSR must be manualized or delivered in accordance with a nationally accepted protocol. PSR is directed toward a particular symptom and works on increasing or reducing a particular behavior.

- PSR may include the following 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;
  - Supporting the restoration and rehabilitation of social and interpersonal skills to increase community tenure, enhance personal relationships, established support networks, increased community awareness, develop coping strategies and effective functioning in the individual's social environment, including home, work and school; and
  - Supporting the restoration and rehabilitation of daily living skills to improve self-management of the negative effects of psychiatric or emotional symptoms that interfere with a person's daily living. Supporting the individual with development and implementation of daily living skills and daily routines necessary to remain in home, school, work and community.

PSR Provider Qualifications

- Any individual rendering PSR services for a licensed and accredited provider agency shall hold a minimum of one of the following:
  - 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
  - A bachelor's degree from an accredited university or college with a minor in counseling, social work, sociology, or psychology.
  - **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.**

Additional Adult Eligibility Criteria for Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR)

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

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.

Services provided to children and adolescents must include communication and coordination with the family and/or legal guardian, including any agency legally responsible for the care or custody of the child. Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the child's/adolescent's medical record.

Service Delivery

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.

- 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.

Anyone providing mental health services must operate within their scope of practice license.

Evidence-based practices require prior approval and fidelity review on an ongoing basis as determined necessary by the Department.

~~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. Services shall not be provided at an institute for mental disease (IMD).~~

Assessment for CPST and PSR

- Each member must be assessed and shall have a treatment plan developed based on that assessment.
- The assessment and treatment planning components of CPST and PSR services for a licensed and accredited provider agency must be a fully licensed mental health professional.
- Assessments shall be performed by an LMHP, and for children and adolescents shall be completed with the involvement of the primary caregiver.
- For adults, assessments must be performed prior to receiving CPST and/or PSR and at least every 365 days, until discharge. Assessments must also be performed any time there is a significant change to the member's circumstances.
- For youth, assessments must be performed prior to receiving CPST and/or PSR and at least every 180 days until discharge. Assessments must also be performed any time there is a significant change to the member'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-CASII) 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 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.

- **As a part of treatment planning, LMHPs must 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:**
  - **Assessing mental health symptoms; and**
  - **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 must 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.**

Limitations/Exclusions

- The following activities are not considered CPST or PSR including PSH and are therefore not reimbursable:
  - 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;
  - Childcare provided as a substitute for the parent or other individuals responsible for providing care and supervision;

- Respite care;
- Teaching job related skills (management of symptoms and appropriate work habits may be taught);
- 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;
- Transportation;
- Staff training;
- Completion of paperwork when the member and or their significant others are not present. Requiring members to be present only for documentation purposes is not reimbursable;
- Team meetings and collaboration exclusively with staff employed or contracted by the provider where the member and/or their family/caregivers are not present;
- Observation of the member (e.g.in the school setting or classroom);
- Staff Research on behalf of the member;
- Providers may not set up summer camps and build the time as a mental health rehabilitation service;
- 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;
- Contacts that are not medically necessary;
- Covered services that have not been rendered;
- Services rendered that are not in accordance with an approved authorization;
- Interventions not identified in the members treatment plan;
- 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;
- Services provided that are not within the provider's scope of practice;
- Any art, movement, dance, or drama therapies; and
- Any intervention or contact not documented.

Crisis Intervention

Crisis intervention (CI) services are provided to a person who is experiencing a psychiatric crisis and are designed to interrupt and/or ameliorate a crisis experience, through a preliminary assessment, immediate crisis resolution and de-escalation and referral and linkage to appropriate community services to avoid more restrictive levels of treatment. The goals of Cis are symptom reduction, stabilization and restoration to a previous level of functioning. All activities must occur within the context of a potential or actual psychiatric crisis. CI is a face-to-face intervention and can occur in a variety of locations, including an emergency room or clinic setting, in addition to other community locations where the person lives, works, attends school and/or socializes.

- Crisis Intervention may include the following components:
  - 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.
  - Short-term CIs, including crisis resolution and debriefing with the identified Medicaid-eligible individual.
  - Follow up with the individual and, as necessary, with the individuals' caretaker and/or family members.
  - Consultation with a physician or with other qualified providers to assist with the individuals' specific crisis.
  - For Crisis Intervention, 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 an individual to his/her best age-appropriate functional level.
  - All individuals who self-identify as experiencing a seriously acute psychological/emotional change, which results in a marked increase in personal distress, and which exceeds the abilities and the resources of those involved to effectively resolve it, are eligible.
  - An individual in crisis may be represented by a family member or other collateral contact that has knowledge of the individual's capabilities and functioning. Individuals in crisis who require this service may be using substances during the crisis, and this will not, in and of itself, disqualify them for eligibility for the service.
  - Substance use should be recognized and addressed in an integrated fashion, as it may add to the risk, increasing the need for engagement in care.
  - The crisis plan developed by the non-licensed professional, in collaboration with the treatment team and LMHP, must be provided under the supervision of an LMHP with experience regarding this specialized mental health service. The LMHP must be available at all times to provide back up, support and/or consultation from assessment of risk and through all services delivered during a crisis.
  - ~~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 shall comply with current, applicable scope of practice and supervisory requirements identified by their respective licensing boards.~~

Crisis Stabilization for Youth & Adults – Bed Based Services

Crisis Stabilization for Youth

Crisis stabilization (CS) 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)).

- ~~Crisis Stabilization may include the following components:~~
  - ~~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;~~
  - ~~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;~~

- ~~CS includes follow up with the individual and with the individual's caretaker and/or family members; and~~
- ~~CS includes consultation with a physician or with other qualified providers to assist with the individual's specific crisis~~.

Components

- 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;
- 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;
- CS includes follow up with the individual and with the individual's caretaker and/or family members; and
- CS includes consultation with a physician or with other qualified providers to assist with the individual's specific crisis.

Service Delivery

Modes of delivery:

- Individual; and
- On-site.

Limitations/Exclusions

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

- Services rendered in an institute for mental disease; and
- The cost of room and board. The minimum daily rate on file is an all-inclusive rate.

NOTE: 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.

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. This 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 temporary twenty-four (24) hours a day, seven (7) days a week support and is not intended to be a housing placement.

CS assists with deescalating the severity of a member's level of distress and/or need for urgent care associated with a mental health disorder. The goal is to support members in ways that will mitigate the need for higher levels of care, further ensuring the coordination of a successful return to community placement at the earliest possible time. Short-term crisis bed-based stabilization services include a range of resources that can meet the needs of the member with an acute psychiatric crisis and provide a safe environment for care and recovery. Care coordination is a key element of crisis services, coordinating across the services and beyond depending on the needs of the member.

Services are provided in an organized bed-based non-medical setting, delivered by appropriately trained staff that provide safe twenty-four (24) hour crisis

relieving/resolving intervention and support, medication management, observation and care coordination in a supervised environment where the member is served. While these are not primary substance use treatment facilities, the use of previously initiated medication assisted treatment (MAT) may continue.

Eligibility Criteria for Adults

- The medical necessity for 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. Referrals to CS must be completed by the Mobile Crisis Response (MCR), Behavioral Health Crisis Care (BHCC), Community Brief Crisis Support (CBCS) providers or ACT teams.
- Other referrals will be considered on a case-by-case basis. This service is intended for any member in mental health crisis, needing immediate intervention to stabilize the situation and needing help now but is whose needs do not meet a higher level of care (examples include not at medical risk or currently violent).
- While medical clearance will not be required, members admitted to this level of care should be medically stable. Members who have a co-morbid physical condition that requires nursing or hospital level of care or who are a threat to themselves or others and require an inpatient level of care are not eligible for CS services.

Components

- Assessment
  The psychiatric diagnostic evaluation of risk, mental status and medical stability must be conducted by a licensed mental health professional (LMHP) or psychiatrist with experience regarding this specialized mental health service and practicing within the scope of his or her professional license. This assessment should build upon what is learned by previous crisis response providers or the Assertive Community Treatment (ACT) provider and should include contact with the member, family members or other collateral sources (e.g., caregiver, school personnel) with pertinent information for the purpose of the evaluation and/or referral to and coordination with other alternative behavioral health services at an appropriate level. If the member expressly refuses to include family or other collaterals sources, it must be documented in the member record. If a psychiatric diagnostic evaluation was completed within thirty (30) days, another evaluation does not need to be completed at this time, but an update to capture the member's current status must be added to the previous evaluation; and
  - A registered nurse or licensed practical nurse practicing within the scope of his or her license performs a medical screen to evaluate for medical stability.
- Interventions
  - The intervention is driven by the member and is developed by the LMHP, psychiatrist, or non-licensed staff in collaboration with the LMHP or the psychiatrist building on and updating the strategies developed by the mobile crisis response (MCR), Behavioral Health Crisis Care (BHCC), and/or community brief support service (CBCS) service providers. Through this process, short-term goals are set to ensure stabilization, symptom reduction and restoration to a previous level of functioning:
  - The intervention should be developed with input from the member, family and other collateral sources. Strategies are developed for the member to use post current crisis to mitigate risk of future incidents until the member engages in alternative services, if appropriate.
  - The service will include brief interventions using person centered approaches, such as, crisis resolution, self-help skills, peer support services, social skills, medication support, and co-occurring substance use disorder treatment services through individual and group interventions. The service must be provided under the supervision of an LMHP or psychiatrist with experience regarding this specialized behavioral health service;

- Substance use should be recognized and addressed in an integrated fashion, as it may add to the risk, increasing the need for engagement in care; and
- Support, education, and consultation is provided to the member, family, and collateral supports.

- Care Coordination
  - CS providers shall coordinate care for the member following the crisis event as needed. Care coordination includes the following activities:
    - Coordinating the transfer to alternate levels of care within 24 hours when warranted, including but not limited to:
      - Primary medical care - when the member requires primary medical care with an existing provider;
      - Community based behavioral health provider - when the member requires ongoing support at a lower level of care with the member's existing behavioral health provider. The member should return to existing services as soon as indicated and accessible;
      - Community Brief Crisis Support (CBCS) - when the member requires ongoing support at home or in the community, if the member does not have an existing behavioral health provider who can meet their current critical needs as defined in the discharge plans;
      - 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, at immediate suicide risk, or currently violent;
      - Inpatient treatment - when the member is in medical crisis, experiencing severe intoxication or withdrawal episodes, or is actively suicidal, homicidal, gravely disabled, or currently violent; and
      - Residential substance use treatment - when the member requires ongoing support outside of the home for a substance use disorder.

NOTE: Crisis care should continue until the crisis is resolved and the member no longer needs crisis services. Readiness for discharge is evaluated on a daily basis.

    - Coordinating contact through a warm handoff with the member's Managed Care Organization (MCO) to link the member with no current behavioral health provider and/or primary medical care provider to outpatient services as indicated;
    - Coordinating contact through a warm handoff with the member's existing or new behavioral health provider; and
    - Providing any member records to the existing or new behavioral health provider or to another crisis service to assist with continuing care upon referral.

- Follow-Up
  - Provide follow up to the member and authorized member's caretaker and/or family up to 72 hours to ensure continued stability post crisis for those not accessing CBCS or higher levels of care, including but not limited to:
    - Telephonic follow-up based on clinical individualized need; and
    - Additional calls/visits to the member following the crisis unless the member indicates no further communication is desired as documented in the member's record.

Service Utilization

- ~~CS requires prior authorization, 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 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.~~
- **CS requires 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 MCE 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.

- The LMHP or psychiatrist must be available at all times to provide back up, support and/or consultation through all services delivered during a crisis.

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.

Service Delivery

- All mental health services must be medically necessary in accordance with the Louisiana Administrative Code LAC 50:1.1101. The medical necessity for services shall be determined by an LMHP or physician who is acting within the scope of his or her 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 or gender identities and other cultural and linguistic groups; and
  - Appropriate for age, development; and education.
- Modes of Delivery
  - On-Site
- Provider Responsibilities
  - All services shall be delivered in accordance with federal and state laws and regulations, the applicable Louisiana Medicaid Provider manual and other notices or directives issued by the Department. The provider shall create and maintain documents to substantiate that all requirements are met. (See Section 2.6 of this manual chapter regarding record keeping);
  - Any licensed practitioner providing behavioral health services must operate within the scope of practice of his or her license; and
  - The provider shall maintain treatment records that include the name of the individual, a treatment plan, the dates of services provided, the nature and content of the services provided, and progress made toward functional improvement and goals in the treatment plan.

Limitations/Exclusions

- The following services shall be excluded from Medicaid coverage and reimbursement:
  - Services rendered in an institute for mental disease; and
  - The cost of room and board;
  - Crisis stabilization shall not duplicate any other Medicaid State Plan service or service otherwise available to the member at no cost;
  - **The per diem for CS and BHCC cannot be billed on the same day;**
  - **Restraints and seclusion cannot be used in CS.**

Functional Family Therapy (FFT) and FFT– Child Welfare

Functional Family Therapy (FFT) is a systems-based model of prevention and intervention that incorporates various levels of the member's interpersonal experiences to include cognitive, emotional and behavioral experiences, as well as interpersonal perspectives which focus on the family and other systems within the environment that impact the member and their family system.

FFT is a strengths-based model that emphasizes the use of existing resources of the member, their family and those of the involved multi-system. The goal is to foster resilience and decrease incidents of disruptive behavior. The service aims to reduce intense/negative behavioral patterns, improve family communication, parenting practices

and problem-solving skills, and increase the family's ability to access community resources.

FFT services target members between the ages of 10-18 primarily demonstrating significant externalizing behaviors or at risk for developing more severe behaviors, which affect family functioning. Behaviors include antisocial behavior or acts, violent behaviors and other behavioral issues that impair functioning. The member may also meet criteria for a disruptive behavior disorder (ADHD, ODD and/or conduct disorder). Members with other mental health conditions, such as anxiety and depression, may also be accepted as long as the existing condition manifests in outward behaviors that impact the family and multiple systems. Youth with substance use issues may be included if FFT is deemed clinically more appropriate than focused drug and alcohol treatment and acting out behaviors are present to the degree that function is impaired, and the criteria listed below is met.

Functional Family Therapy – Child Welfare (FFT-CW) services are targeted for youth (age 0-18) and families with suspected or indicated child abuse or neglect. Problems include youth truancy, educational neglect, parental neglect or abuse, a history of domestic violence, adult caregiver substance use, and adult caregiver anxiety, depression and other mental health issues. Youth may also meet criteria for a disruptive behavior disorder (ADHD, oppositional defiant disorder and/or conduct disorder). Youth with other mental health conditions, such as anxiety and depression, may also be accepted as long as the existing mental and BH issues manifest in outward behaviors that impact the family and multiple systems. Youth with substance use issues may be included if they meet the criteria below, and FFT-CW is deemed clinically more appropriate than focused drug and alcohol treatment. However, acting out behaviors must be present to the degree that functioning is impaired, and the criteria listed below is met.

Admission Criteria

The member is not in imminent or current risk of harm to self, others, and/or property.

- ~~AND~~
- The member is 10-18 years old for FFT; Families of youth, ages 0-18 for FFT-CW.
- ~~AND~~
- At least one adult caregiver is available to provide support and is willing to be involved in treatment.
- ~~AND~~
- The member's DSM-5 diagnosis is the primary focus of treatment and symptoms, and impairment are the result of a primary disruptive/externalizing behavior disorder, although internalizing psychiatric conditions and substance use disorders may be secondary.
- ~~AND~~
- Functional impairment is not solely a result of pervasive developmental disorder or intellectual disability.
- ~~AND~~
- The member displays externalizing behavior which adversely affects family functioning. The member's behaviors may also affect functioning in other areas.
- ~~AND~~
- Documented medical necessity for an intensive in-home service.

Continuing Stay Criteria

- The member receives an average of 12 to 30 one-to-two-hour sessions in the home or community depending on the member's needs over the course of 3-5 months.
- **There are four domains of assessment used to monitor progress towards goals including the**
- **following:**
  - **Member assessment (through the use of the outcomes questionnaire (OQ) family measures pre-assessment, risk and protective factors assessments pre-assessment, relational assessment):**

        - a. Helps understand individual, family and behavior in a context functioning; and
        - b. Adds to clinical judgment, helps target behavior change targets, tool in treatment.
    - ~~Adherence assessment (through the use of the Family Self Report and Therapist Self Report, and Clinical Services System (CSS) tracking/adherence reports, global therapist ratings):~~
        - ~~a. Identifies adherence to FFT/FFTCW to enhance learning and supervision; and~~
        - ~~b. Judges clinical progress, monitor clinical decisions.~~
    - Outcome assessment (through the use of therapist outcome measure, counseling outcome measure parent/adolescent and post assessment OQ family measures and post risk and protective factors assessment):
        - a. Helps understand the outcome of your work – accountability; and
        - b. Identifies changes in member functioning (pre-post).
- NOTE: The term "counseling" throughout the FFT section is in keeping with the nomenclature of this evidenced based practice and should not be mistaken for the counseling and psychotherapy rendered by LMHPs under their respective scope of practice license.
    - Case monitoring and tracking (member service system reports):
        - a. Every member contact/planned contact, outcome of that contact (helps monitor practice).

Discharge Criteria

- The member and family demonstrate their ability to utilize resources within the community and demonstrate integration prior to discharge.

Service Delivery

- On average, a youth receives FFT/FFT-CW for approximately 3 to 5 months. Over the course of this period, the therapist works with the family in twelve to fifteen one- to two-hour sessions for less severe cases and up to 30 -one- to two-hour sessions for youth with more complex needs. The frequency of the sessions varies on a case-by-case basis and over the course of the treatment; sessions could occur daily to weekly, as needed. Services occur in the office, family's home and/or community at times that are convenient for the family. In addition to being available to families as needed (intensity is based on family risk and protective factors), FFT/FFT-CW therapists provide regular telephonic follow-up and support to families between sessions.
- Outreach and linkages made with community supports are an essential part of the model, particularly during pre-treatment, engagement, and generalization phases; this includes non-face-to-face and telephonic contact with these sources, with or without the member present.
- The FFT/FFT-CW therapist must work with any treatment planning team, including the wraparound facilitator (WF) through the Coordinated System of Care (CSoC), to develop an individualized treatment plan.

Exclusions

- FFT shall not be billed in conjunction with PRTF services.
- As standard practice, FFT/FFT-CW may be billed with medication management and assessment. FFT may also be billed in conjunction with another behavioral health service (such as individual therapy, Community Psychiatric Support and Treatment (CPST), Psychosocial Rehabilitation (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/FFT-CW service and by the concurrent service; and

- **The services are delivered in coordination of each other to ensure no overlap or contradiction in treatment.**

Homebuilders

Homebuilders® is an intensive, in-home Evidence-Based Program (EBP) utilizing research-based strategies (e.g., Motivational Interviewing, Cognitive and Behavioral Interventions, Relapse Prevention, Skills Training), for families with children (birth to 18 years) at imminent risk of out of home placement (requires a person with placement authority to state that the child is at risk for out of home placement without Homebuilders) or being reunified from placement. Homebuilders® is provided through the Institute for Family Development (IFD).

- Homebuilders® participants demonstrate the following characteristics:
  - Children/youth with serious behavioral and/or emotional problems in the home, school, and/or community;
  - Family members with substance abuse problems, mental health problems, poverty-related concerns (lack of adequate housing, clothing and/or food);
  - Babies that were born substance-exposed or considered failure to thrive;
  - Teenagers/adolescents that run away from home, have suicidal risk, have attendance and/or behavioral problems at school, have drug and alcohol use, and/or experience parent-teen conflict(s);
  - Children/youth who have experienced abuse, neglect, or exposures to violence or other trauma.

- The goals of Homebuilders® are to reduce child abuse and neglect, family conflict, and child behavior problems, and improve parenting skills, family interactions, and family safety to prevent the imminent need for placement or successfully reunify children.
- The Homebuilders® model is designed to eliminate barriers to service while using research-based interventions to improve parental skills, parental capabilities, family interactions, children's behavior, and well- being, family safety and the family environment.
- The children are returning from, or at risk of, placement into foster care, group or residential treatment, psychiatric hospitals or juvenile justice facilities.
- Homebuilders® is specifically aimed toward children and families identified with:
  - Caregiver and/or child emotional/behavioral management problems;
  - Trauma exposure;
  - Incorrigibility;
  - Academic problems;
  - Delinquency;
  - Truancy;
  - Running away;
  - Family conflict and violence;
  - Poor/ineffective parenting skills;
  - Single parent families;
  - Sibling antisocial behavior;
  - Parental/caregiver use of physical punishment, harsh, and/or erratic discipline practices;
  - Substance use;
  - Mental health concerns (depression/mood disorders, anxiety, etc.); and/or
  - Additional topics such as: poverty, lack of education, substandard housing, lack of supports and resources.
- The primary intervention components of the Homebuilders model are engaging and motivating family members, conducting holistic, behavioral assessments of strengths and problems, developing outcome-based goals. Therapists provide a wide range of counseling services using research-based motivation enhancement and cognitive behavioral interventions, teaching skills to facilitate behavior change and developing and enhancing ongoing supports and resources. In addition, therapists help families

enhance their social support network and access basic needs such as food, shelter, and clothing.

- **NOTE: The term "counseling" throughout the Homebuilders® section is in keeping with the nomenclature of this evidenced based practice and should not be mistaken for the counseling and psychotherapy rendered by licensed medical health professionals (LMHPs) under their respective scope of practice license**.
- Homebuilders® consists of:
  - Intensity: An average of eight to ten hours per week of face-to-face contact, with telephone contact between sessions. Services average 38 face-to-face hours. Therapists schedule sessions during the day, evening and on weekends with 3-5 or more sessions per week based on safety and intervention needs;
  - Duration: Four to six weeks. Extensions beyond four weeks must be approved by the Homebuilders consultant. Two aftercare 'booster sessions' totaling five hours are available in the six months following referral. Additional booster sessions can be approved by the Homebuilders consultant; and
  - Crisis Intervention: Homebuilders therapists are available 24/7 for telephone and face to face crisis intervention.

Admission Criteria

- The member is not in imminent or current risk of harm to self, others, and/or property.
- AND
- The family has a child/children ages birth to 18 years old at imminent risk of out of home placement due to at least one of the following:
  - Caregiver and/or child emotional/behavioral management problems
  - Trauma exposure
  - Incorrigibility
  - Academic problems
  - Delinquency
  - Truancy
  - Running away
  - Family conflict and violence
  - Poor/ineffective parenting skills
  - Single parent families
  - Sibling antisocial behavior
  - Parental/caregiver use of physical punishment, harsh, and/or erratic discipline practices
  - Substance use
  - Mental health concerns (depression/mood disorders, anxiety, etc.)
  - Additional topics such as: poverty, lack of education, substandard housing, lack of supports and resources
- AND
- Other than psychological evaluation or assessment and medication management, all behavioral health services are provided by Homebuilders.
- AND
- The member is not receiving residential services including professional resource family care.

Continuing Stay Criteria

- The member is receiving an average of 8 to 10 hours per week of face-to-face contact, with telephone contact between sessions. Services average 38 face-to-face hours. Therapists schedule sessions during the day, evening and on weekends with 3-5 or more sessions per week based on safety and intervention needs.
- AND
- Homebuilders' therapists are available 24/7 for telephone and face to face crisis intervention.

Discharge Criteria

- The duration of services is 4 to 6 weeks. Extensions beyond 4 weeks must be approved by the Homebuilders consultant. Two aftercare 'booster sessions' totaling 5 hours are available in the 6 months following referral. Additional booster sessions may be approved.

Exclusions

- When Homebuilders® is utilized for clinical goals of a Medicaid eligible individual, Medicaid will reimburse. When Homebuilders® is utilized for the clinical goals of a non-Medicaid individual or other goals consistent with the Homebuilders® model, the referring agency or the family will reimburse. Homebuilders® may also be used for stabilization referrals where children are transitioning from a more restrictive to a less restrictive placement (such as a move from a group home to foster home or relative, only for stabilization purposes) or may be used for to stabilize a foster placement that is at risk of dissolution as long as the child demonstrates the listed characteristics.

Individual Placement and Support

Individual Placement and Support Services refers to the evidence-based practice of supported employment for members with mental illness. IPS helps members living with mental health conditions work at regular jobs of their choosing that exist in the open labor market and pay the same as others in a similar position, including part-time and full-time jobs. IPS helps people explore the world of work at a pace that is right for the member. Based on member's interests, IPS builds relationships with employers to learn about the employers' needs in order to identify qualified job candidates. The job search is based on individual preferences, strengths, and work experiences, not on a pool of jobs that are readily available or the IPS specialist's judgment. Job seekers indicate preferences for job type, work hours, and types of job supports. Job supports are individualized based on the needs of the member and what will promote a positive work experience. IPS offers help with job changes career development and career advancement, including additional schooling and training, assistance with education, a more desirable job, or more preferred job duties. The majority of IPS services must be provided in the community.

IPS provides competitive job options that have permanent status rather than temporary or time-limited status. Competitive jobs pay at least minimum wage, are jobs that anyone can apply for and are not set aside for people with disabilities. IPS offers to help with another job when one has ended, regardless of the reason that the job ended, or number of jobs held. Some people try several jobs before finding employment they like. Each job is viewed as a positive learning experience. If a job is a poor match, an IPS specialist offers to help the member find a new job based upon lessons learned. IPS follows the philosophy that all choices and decisions about work, further schooling, technical training and support are individualized based on the member's preferences, strengths, and experiences. In IPS, members are encouraged to be as independent as possible and IPS specialists offer support as needed.

Admission Criteria

- The member meets **medical necessity criteria in accordance with LAC 50:I.1101 may receive IPS when recommended by an LMHP or physician within their scope of practice. Members must be:** ~~the LA definition of Medical Neccessityiii~~
- The member is at least 21 years of age; and
- The member has transitioned from a nursing facility or been diverted from nursing facility level of care;
- All members meeting the above criteria who are interested in working have access to this service. Members are not excluded on the basis of job readiness, diagnoses, symptoms, substance use history, substance abuse, mental health symptoms, history of violent behavior, cognition impairment, treatment non-adherence, homelessness, work

history, psychiatric hospitalizations, homelessness, level of disability, legal system involvement, or personal presentation.

Service Delivery

- **Services are subject to prior authorization.**
- 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. 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:
  - The employment unit has weekly client-based 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.
  - IPS specialists attach to one (1) or two (2) mental health treatment teams, from which at least 90% of the employment specialist's caseload is comprised.
  - IPS specialists actively participate in weekly mental health treatment team meetings (not replaced by administrative meetings) that discuss individual members and their employment goals with shared decision-making.
- Members are not asked to complete vocational evaluations (e.g., paper and pencil vocational tests, interest tests, and work samples), situational assessments (such as short-term work experiences), prevocational groups, volunteer jobs, short-term sheltered work experiences, or other types of assessment in order to receive assistance obtaining a competitive job.
- Initial vocational assessment occurs over 2-3 sessions, is updated with information from work experiences in competitive jobs and aims at problem solving using environmental assessments and consideration of reasonable accommodations, such as but not limited to American Disability Act (ADA) requirements to encourage an atmosphere of productivity considering the member's diagnosis.
- A vocational profile form that includes information about preferences, experiences, skills, current adjustment, strengths, personal contacts, etc., is updated with each new job experience. Sources of information include the member, treatment team, clinical records, and with the member's permission, from family members and previous employers. The vocational assessment (referred to as the "career profile") leads to individualized employment and education planning. The career profile is updated with each new employment and education experience. The purpose is not to determine employability, but to learn what the member enjoys, skills and experiences, and what will help the member achieve goals. Initial employment assessment occurs within 30 days after program entry.
- An individualized job search plan is developed and updated with information from the vocational assessment/profile form and new job/educational experiences.
- IPS specialists systematically visit employers, who are selected based on the job seeker's preferences, to learn about their business needs and hiring preferences. Each IPS specialist makes at least 6 face-to-face employer contacts per week on behalf of members looking for work. An employer contact is counted even when an employment specialist meets the same employer more than one time in a week, and when the member is present or not present. Member-specific and generic contacts are included. IPS specialists use a weekly tracking form to document employer contacts.
- IPS programs use a rapid job search approach to help job seekers obtain jobs rather than assessments, training, and counseling. IPS specialists help members look for jobs soon after entering the program instead of requiring pre-employment assessment and training or intermediate work experiences, such as prevocational work units, short-

term jobs to assess skills, transitional employment, agency-run businesses or sheltered workshops. The first face to face contact with the employer by the member or the IPS specialist occurs within 30 days.

- IPS specialists ensure that members are offered comprehensive and personalized benefits planning, including information about how work may affect their disability and government benefits. The purpose is to help members make informed decisions about job starts and changes. In all situations members are encouraged to consider how working and developing a career may be the quickest way to avert poverty or dependence on benefits. All members are offered assistance in obtaining comprehensive, individualized work incentives (benefits) planning before starting a new job and assistance accessing work incentives planning thereafter when making decisions about changes in work hours and pay. Work incentives planning includes SSA benefits, medical benefits, medication subsidies, housing subsidies, food stamps, spouse and dependent children benefits, past job retirement benefits, and any other sources of income.
- 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.
  - 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 documented efforts to meet with members at least monthly for a year or more, on average, after working steadily, and desired by members.
  - Members are transitioned to step down job supports from a mental health worker following steady employment. 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.
- Service termination is not based on missed appointments or fixed time limits.
  - Engagement and outreach attempts made by integrated team members are systematically documented, including multiple home/community visits, coordinated visits by IPS specialist with integrated 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 stops outreach.
- 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 member receiving services;
  - Appropriate to members of diverse racial, ethnic, religious, sexual and gender identities and other cultural and linguistic groups; and
  - Appropriate for age, development, and education;
  - Any licensed practitioner providing behavioral health services must operate within their license and scope of practice.

Limitations/Exclusions

- **IPS services shall not duplicate any other Medicaid State Plan service or service otherwise available to the member at no cost;**
- **IPS services are provided to members who are not served by the Louisiana Workforce Commission's Louisiana Rehabilitation Services (LRS) organization and need more intensive supports;**
- **IPS services may not be provided if the service is otherwise available under a program funded under the Rehabilitation Act of 1973; and**
- **Incentive payments, subsidies, or unrelated vocational training expenses may not be billed such as but not limited to: incentive payments made to an employer to encourage or subsidize the employer's participation in a IPS program; payments that are passed through to users of IPS programs; or payments for vocational training that is not directly related to a member's IPS program.**

- **Crisis Response Services** are provided to form a continuum of care offering relief, resolution and intervention through crisis supports and services to decrease the unnecessary use of emergency departments and inpatient hospitalizations for members whose needs are better met in the community. These services are available twenty-four (24) hours a day, seven (7) days a week. Care coordination is a key element across all of these services, coordinating across the services and beyond depending on the needs of the member. Providers delivering these services will respond to crises by initiating the least restrictive response commensurate with the risk. This level of care involves supporting and collaborating with the member to achieve symptom reduction by delivering brief, resolution-focused treatment, problem solving and developing useful safety plans that will assist with community tenure. These services are intended for members with urgent mental health distress only.
- Crisis response services are not intended for and should not replace existing behavioral health services. Rather, crisis response services should be used for new or unforeseen crises not otherwise addressed in the member's existing crisis plan. Unless directly referred to Community Brief Crisis Support (CBCS) by the managed care organization (MCO), these services are not to be utilized as step down services from residential or inpatient psychiatric or Substance Use Disorder (SUD) treatment service settings.
- Crisis response services are not intended to substitute for already-approved and accessible Community Psychiatric Support and Treatment (CPST), Psychosocial Rehabilitation (PSR), or Assertive Community Treatment (ACT) services with a member's already-established provider. For individuals under the age of 21, 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 Program (CSoC).

~~Service Delivery~~ Common Components

Preliminary Screening[HR1]

- A brief preliminary, person-centered screening of risk, mental status, medical stability and the need for further evaluation or other mental health services shall be conducted. This screening and shall include contact with the member, family members or other collateral sources with pertinent information for the purpose of the screening and/or referral to and coordination with other alternative behavioral health services at an appropriate level; and
- When a member is referred from another crisis provider, the screening of risk, mental status and medical stability and the need for further evaluation or other mental health services builds on the screening and assessments conducted by the previous crisis service providers.

Assessments

- If further evaluation is needed, an assessment must be conducted by a licensed mental health professional (LMHP) or psychiatrist with experience regarding this specialized mental health service. This evaluation shall include contact with the member, family members or other collateral sources with pertinent information for the purpose of the assessment and/or referral to and coordination with other alternative behavioral health services at an appropriate level. If the member expressly refuses to include family or other collaterals sources, it must be documented in the member record; and
- When a member is referred from another crisis provider, if further evaluation is needed, the assessment builds on the screening or assessments conducted by the previous crisis service providers.

Interventions

- 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 their professional license and applicable state law:
  - When a member is referred from another crisis provider to CBCS, the intervention is driven by the member and is developed by the LMHP, psychiatrist or non-licensed staff in collaboration with the LMHP or psychiatrist building on and updating the strategies developed by the MCR or BHCC providers; and
  - For services delivered to minors under the age of 18, the interventions focus on the crisis experience of the minor and the experience of the person with parental authority whose minor 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 minor 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 minor in crisis.
- Short-term goals are set to ensure stabilization, symptom reduction and restoration to a previous level of functioning. The intervention shall be developed with input from the member, family and other collateral sources;
- Interventions include using person-centered approaches, such as crisis resolution and debriefing with the member (and caregiver, when present for minor-directed services) experiencing the crisis for relief, resolution and problem solving of the crisis;
- Substance use shall be recognized and addressed in an integrated fashion, as it may add to the risk, increasing the need for engagement in care; and
- Support, education, and consultation is provided to the member, family, and collateral supports.

Care Coordination

- All levels of crisis providers shall coordinate care for the member following the crisis event as needed. Care coordination includes the following activities:
  - Coordinating the transfer to alternate levels of care within 24 hours when warranted, including but not limited to:
    - Primary medical care - Member requires primary medical care with an existing provider;
    - Community based behavioral health provider - Member requires ongoing support at a lower level of care with the member's existing behavioral health provider. The member shall return to existing services as soon as indicated and accessible;
    - Behavioral Health Crisis Care (BHCC) Center for adults - Member requires ongoing support and time outside of the home;
    - Community Brief Crisis Support (CBCS) - Member requires ongoing support at home or in the community subsequent to an initial crisis;
    - Crisis Stabilization (CS) – 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;
    - Inpatient treatment – Member is in medical crisis, experiencing severe intoxication or withdrawal episodes, actively suicidal, homicidal, gravely disabled, or currently violent; and
    - Residential substance use treatment - Member requires ongoing support and treatment outside of the home for a SUD.
- NOTE: Crisis care shall continue until the crisis is resolved, the member has met with the accepting behavioral health treatment provider of ongoing care, or until the member no longer needs crisis services.

- Coordinating contact through a warm handoff with the member's MCE to link the member with no current behavioral health provider and/or primary medical care provider to outpatient services as indicated;
- Coordinating contact through a warm handoff with the member's existing or new behavioral health provider. For individuals under the age of 21, this may include warm handoff with the member's wraparound agency if the individual is enrolled or has been referred to CSoC; and
- Providing any member records to the existing or new behavioral health provider or another crisis service to assist with continuing care upon referral.

Planning and Delivery of Services

- There shall be member involvement throughout the planning and delivery of services. Services shall be:
  - 1. Delivered in a culturally and linguistically competent manner;
  - 2. Respectful of the individual receiving services;
  - 3. Appropriate to individuals of diverse racial, ethnic, religious, sexual or gender identities and other cultural and linguistic groups; and
  - 4. Appropriate for the individual's age, development, and education.

Documentation

- All crisis providers shall maintain case records that include, at a minimum:
  - 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;
  - Dates, and time of service;
  - Place of services, for MCR and CBCS services;
  - Preliminary screening;
  - Assessments (if necessary);
  - Intervention notes;
  - Documentation of coordination attempts;
  - Discharge summary; and
  - Consent for treatment, including:
    - a. 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 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. 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
    - b. Consent needed for non-emergencies
    - **c.** Providers must obtain oral or written consent, 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, treatment of a minor (under the age 18 during a non-emergency, documentation of consent for treatment shall include consent from the documentation of consent for treatment shall include consent from the minor, parent, or person with legal authority to act on the minor's behalf.
- The preliminary screening shall include, at a minimum, the reason for presentation, nature of the crisis, chief complaint, medical stability, grave disability and risks of suicidality, of self-harm, and of danger to others. If further evaluation is needed, an assessment must be conducted by an LMHP or psychiatrist with experience regarding this specialized mental health service. The assessment shall include a mental status exam and a current behavioral health history including the current behavioral health provider.
- Notes on the interventions delivered shall be written after every encounter. All follow-up encounters and attempts shall be documented. The member's record must

reflect relief, resolution and problem solving of the identified crisis or referral to an alternate provider.

- Attempts to communicate with treating providers and family, when possible, shall be documented.
- The discharge summary shall include communications with treating providers and family when possible. A brief crisis plan/strategies are developed for the member to use post current crisis to mitigate the risk of future incidents until the member engages in alternative services, if appropriate.

Mobile Crisis Response (MCR) – expansion to ages under 21, effective 04/01/2024. MCR services are an initial or emergent crisis response intended to provide relief, resolution and intervention through crisis supports and services during the first phase of a crisis in the community. MCR is a face-to-face, time-limited service provided to a member who is experiencing a psychiatric crisis until the member experiences sufficient relief/resolution and the member can remain in the community and return to existing services or be linked to alternative behavioral health services which may include higher levels of treatment like inpatient psychiatric hospitalization.

MCR providers are dispatched after an initial triage screening determines that MCR is the most appropriate service. MCR services are available 24 hours a day, seven days a week and must include maximum one hour urban and two hour rural face-to-face/onsite response times.

~~For[HR2] individuals under the age of 21, 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 individuals enrolled in the Coordinated System of Care (CSoC) program.~~

Admission Criteria

- The medical necessity for 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 a member aged 21 years and over to their best age-appropriate functional level. Members in crisis who require this service may be using substances during the crisis, and substance use will not, in and of itself, disqualify them for eligibility for the service.
- All members who self-identify as experiencing a seriously acute psychological/emotional change, that results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved to effectively resolve it, are eligible for initial/emergent crisis services as long as medical necessity is met.
- For minors under the age of 18, eligibility for initial/emergent crisis services based on "self-identification" that the member is experiencing a crisis includes self-identification by the minor and identification by the current physical caregiver to the minor, under the principle that "the crisis is defined by the caller." The caller, who identifies the crisis and initiates MCR services for minor, may commonly be an adult currently serving in a caregiving role to the minor in the setting where the crisis is being experienced. This may include, but is not limited to:
  - Caregivers in a home setting, including a parent, person with legal authority to act on the minor's behalf, foster parent, fictive kin, or other family member serving in a caregiving role in the home or community setting at the time that the minor is experiencing the crisis;
  - Teacher or staff in a school setting where the minor is experiencing a crisis;
  - Care staff at a group home setting where the minor currently resides and where the minor is experiencing the crisis; or

- Helping professional accompanying the minor 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 minor 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 person with parental authority during
- the time when the MCR team is dispatching and attempt to gain their consent). 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, to inform them of the situation and to attempt to obtain their consent for treatment.
- While an un-emancipated minor usually needs the consent of a parent or person with legal authority to act on behalf of the minor, 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 person with legal authority to act on the minor's behalf.
- An emergency is defined as a situation wherein:
  - Treatment is medically necessary;
  - Person authorized to consent is not readily available; and
  - 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.
- In these emergency situations, services can and should be provided to the minor, even if attempts to obtain consent from the person with parental authority were unsuccessful, while continued attempts are made to contact the person with parental authority in order to obtain their consent for the services. In the event the parent, or person with legal authority, objects or 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 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.40:1079.1(A). Unless otherwise stated by available legal documentation, an individual who is aged18 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.

~~Consent for Treatment~~

- ~~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. 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

- Consent needed for non-emergencies:
  - Providers must obtain oral or written consent, 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, treatment of a minor (under the age 18 during a non-emergency, documentation of consent for treatment shall include consent from the documentation of consent for treatment shall include consent from the minor, parent, or person with legal authority to act on the minor's behalf.[HR3]

Service Delivery

- For services delivered to minors under the age of 18, the interventions focus on the crisis experience of the minor and the experience of the person with parental authority whose minor 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 minor 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 minor in crisis.
- Interventions include using person-centered approaches, such as crisis resolution and debriefing with the member (and caregiver, when present for minor-directed services) experiencing the crisis for relief, resolution and problem solving of the crisis.
- Coordinating contact through a warm handoff with the member's existing or new behavioral health provider. For individuals under the age of 21, this may include warm handoff with the member's wraparound agency if the individual is enrolled or has been referred to CSoC; and
- Providing any member records to the existing or new behavioral health provider or another crisis service to assist with continuing care upon referral.[HR4]
- Provide services (screening, assessment, interventions, and care coordination) as outlined in the general section; and
- Provide 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 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:
  - 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 individuals under the age of 21; and
  - 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.
- Documentation
  - All crisis providers shall maintain case records that include, at a minimum:
  - 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.
- Service Utilization
  - MCR is an initial crisis response and is allowed without the requirement of a prior authorization in order to address the emergent issues in a timely manner, although providers are required to notify the MCE when its member presents. MCR is intended to provide crisis supports and services during the first 72 hours of a crisis.
  - NOTE: Such initial encounters will be subject to retrospective review. In this way, if it is determined that the response time is beyond one – two hours (e.g., next day or later), and/or if available/reviewed documentation does not support the crisis, the payment might be subject to recoupment.
- Allowed Mode(s) of Delivery
  - Individual;

- On-site (MCR office); or
- Off-site.

- Allowed Places of Service
  - This is primarily a community-based service delivered in member's natural setting with exceptions for office-based when desired or requested by the member. Any exceptions to providing the service in the member's natural setting must include a justification documented in the member record. When preferred, office-based services are permitted; however, it must not be the primary mode of service delivery. For minors under the age of 18, 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 individual
  - 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. In addition, the following core staffing requirements for the
  - program must be followed:
    - Medical director or designated prescriber (physician/psychiatrist, APRN, medical psychologist) must be available 24 hours a day /seven 7 days a week for consultation and medication management;
    - ~~LMHPs on duty to adequately meet the member's needs; and~~[HR5]
    - **Qualified licensed professionals to provide assessment and meet the member's needs during initial and follow up response; and**
    - RPSS or RFPSS on duty to adequately meet the member's needs.
- Response Team Staffing Requirements
  - Unlicensed staff and RPSS deploy in teams initially to assess and address the crisis, only enlisting the assistance of an LMHP if needed. Exceptions to the team deployment may be made by the team leader; and
  - One staff person may deploy after the initial assessment, if appropriate as determined by the team leader.
  - **A 2-person team must dispatch in person. This must be met by one of the following staffing combinations[HR6]:**
    - **Two (2) RFPSS or RPSS;**
    - **One (1) RFPSS or RPSS and an unlicensed professional; or**
    - **One (1) RFPSS or RPSS and a qualified licensed professional.**
    - **If not dispatching in person, the qualified licensed professional shall participate to assess and provide clinical intervention throughout the crisis response via telemedicine; and**
    - **One staff person may deploy after the initial dispatch and during the period in which follow up is provided (up to 72 hours post initial intervention). The level of staff deployed shall be appropriate to the follow up needs of the member as determined by the qualified licensed professional supervising clinical interventions.**
- Allowed Provider Types and Specialties
  - PT 74 Mental Health Clinic PS 70 Clinic / Group PSS 8E CSoC/ Behavioral Health;
  - PT 77 Mental Health Rehab PS 78 MHR; and
  - PT AF Crisis Receiving Center, PS 8E CSoC/Behavioral Health.

Billing

- 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;
- The initial MCR dispatch per diem covers the first 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;
- Collateral contacts shall involve contacts with family members or other individuals having a primary relationship with the member receiving treatment and must be for the

benefit of the member. These contacts are encouraged, included within the rate, and are not billed separately; and
- Time spent in travel, documenting, supervision, training, etc. has been factored into the indirect unit cost and may not be billed directly.

Exclusions

- MCR services cannot be rendered in SUD residential facilities or inpatient facilities;
- MCR services cannot be approved for incarcerated individuals; and
- MCR services are not to be utilized as step down services from residential or inpatient psychiatric service settings, or SUD residential service settings.

Behavioral Health Crisis Care

Behavioral Health Crisis Care (BHCC) services are an initial or emergent psychiatric crisis response intended to provide relief, resolution and intervention through crisis supports and services during the first phase of a crisis for adults. BHCC Centers (BHCCC) operate twenty-four (24) hours a day, seven (7) days a week as a walk-in center providing short-term mental health crisis response, offering a community based 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). BHCCC are designed to offer recovery oriented and time limited services up to twenty-three (23) hours per intervention, generally addressing a single episode that enables a member to return home with community-based services for support or be transitioned to a higher level of care as appropriate if the crisis is unable to be resolved.

Admission 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. 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.
- All members who self-identify as experiencing a seriously acute psychological/emotional change, that results in a marked increase in personal distress and that exceeds the abilities and the resources of those involved to effectively resolve it, are eligible for initial/emergent crisis services as long as medical necessity is met.

Continued Stay Criteria

- BHCC is an initial crisis service and is allowed without the requirement of a prior authorization in order to address the emergent issues in a timely manner, although providers are required to notify the MCO when its member presents. If the referral is made from CBCS to BHCC, prior authorization is required.

Discharge Criteria

- BHCC is intended to provide crisis supports and services during the first twenty-three (23) hours of a crisis[HR7].

Service Delivery

- Provide services (screening, assessment, interventions, and care coordination) as outlined in the general section;
- A registered nurse or licensed practical nurse practicing within the scope of his or her license performs a medical screen to evaluate for medical stability; and
- Providing 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:
- Telephonic follow-up based on clinical individualized need; and
- Additional calls/visits to the member following the crisis as indicated in order to stabilize the crisis. If the member indicates no further communication is desired, it must be documented in the member's record.

Exclusions

- BHCC is not to be utilized as step down services from other residential or inpatient psychiatric service settings or Substance Use Disorder residential service settings.
- **The[HR8] 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

Community Brief Crisis Support (CBCS) - expansion to ages under 21, effective 04/01/2024. CBCS services are an ongoing crisis response intended to be rendered for up to 15 days and are designed to provide relief, resolution and intervention through maintaining the member at home/community, de-escalating behavioral health needs, referring for treatment needs, and coordinating with local providers. CBCS is a face-to-face, time-limited service provided to a member (and for minors, the member's caregiver) who is experiencing a psychiatric crisis until the crisis is resolved and the member can return to existing services or be linked to alternative behavioral health services. As determined by the MCE, CBCS can also be provided to individuals who have experienced a presentation to an emergency department for a reason related to emotional distress.

CBCS services are available 24 hours a day, seven days a week. CBCS services are not intended for and must not replace existing behavioral health services. Rather, referrals for services occur directly from MCEs, MCR, BHCC, or CS providers as needed for ongoing follow up and care. This level of care involves supporting and collaborating with the member (and for minors, the member's caregiver) to achieve symptom reduction by problem solving and developing useful safety plans that will assist with community tenure.

Admission 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 to their best age-appropriate functional level. This service will be rendered to eligible members after a referral is made from the MCE, MCR, BHCC, or CS provider. 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.
- All members who self-identify as experiencing a seriously acute psychological/emotional change, that results in a marked increase in personal distress and that exceeds the abilities and the resources of those involved to effectively resolve it, are eligible for ongoing crisis services as long as medical necessity is met and the members is not already linked to an existing MHR or ACT provider.
- For minors under the age of 18, eligibility for crisis services based on "self-identification" that the member is experiencing a crisis includes identification by the minor'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 minor.

~~Consent for Treatment~~

- ~~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. 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~~
- ~~Consent needed for non-emergencies:~~
  - ~~Providers must obtain oral or written consent, 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, treatment of a minor (under the age 18 during a non-emergency, documentation of consent for treatment shall include consent from the documentation of consent for treatment shall include consent from the minor, parent, or person with legal authority to act on the minor's behalf.~~[HR9]

Service Delivery

- ~~For services delivered to minors under the age of 18, the interventions focus on the crisis experience of the minor and the experience of the person with parental authority whose minor 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 minor 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 minor in crisis.~~
- ~~Interventions include using person-centered approaches, such as crisis resolution and debriefing with the member (and caregiver, when present for minor-directed services) experiencing the crisis for relief, resolution and problem solving of the crisis;~~
- ~~Coordinating contact through a warm handoff with the member's existing or new behavioral health provider. For individuals under the age of 21, this may include warm handoff with the member's wraparound agency if the individual is enrolled or has been referred to CSoC; and~~
- ~~Providing any member records to the existing or new behavioral health provider or another crisis service to assist with continuing care upon referral.~~
- ~~Provide services (screening, assessment, interventions, and care coordination) as outlined in the general section; and~~
- ~~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 crisis provider (MCR, BHCC, CS) has discharged the member to ensure continued stability post crisis for those not accessing higher levels of care, including but not limited to:~~
  - ~~Telephonic or face to face follow-up based on clinical individualized need, with face-to-face follow-up highly preferred for service delivery to individuals under the age of 21; and~~
  - ~~Additional calls/visits to the member following the crisis as indicated in order to stabilize the crisis. If the member indicates no further communication is desired, it must be documented in the member's record.~~
- ~~Documentation~~
  - ~~All crisis providers shall maintain case records that include, at a minimum:~~
  - ~~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.~~[HR10]
- Service Utilization
  - CBCS requires prior authorization, 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 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.

- Allowed Mode(s) of Delivery
  - Individual;
  - On-site (CBCS office); or
  - Off-site.
- Allowed Places of Service
  - CBCS is primarily a community-based service delivered in member's natural setting with exceptions for office-based settings when desired or requested by the member or through some other exception as documented in the member record. When preferred, office-based services are permitted, but shall not be the primary mode of service delivery. For minors under the age of 18, 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 minor currently resides.
- Staffing Requirements
  - The CBCS 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:
    - Medical director or designated prescriber (physician/psychiatrist, APRN, medical psychologist) must be available 24 hours a day, /seven days a week for consultation and medication management;
    - LMHPs on duty to adequately meet the member's needs; and
    - RPSS or RFPSS on duty to adequately meet the member's needs.
- Allowed Provider Types and Specialties
  - PT 74 Mental Health Clinic PS 70 Clinic / Group PSS 8E CSoC/ Behavioral Health;
  - PT 77 Mental Health Rehab PS 78 MHR; and
  - PT AF Crisis Receiving Center, PS 8E CSoC/Behavioral Health.

Billing

- 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;
- Time spent in travel, documenting, supervision, training, etc. has been factored into the indirect unit cost and may not be billed directly; and
- CBCS and established behavioral health services may be billed on the same day one time to allow for the hand off.

Exclusions

- CBCS services cannot be:
  - Rendered in SUD residential facilities, PRFT, or inpatient facilities;
  - Approved for incarcerated individuals; and
  - 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 shall not prohibit a brief overlap of services that is necessary for a warm handoff to the accepting provider, when appropriate.

Dialectical Behavioral Therapy

Dialectical Behavioral Therapy (DBT) is a comprehensive, multi-diagnostic, modularized behavioral intervention designed to treat both adults and children/adolescents with severe mental disorders and uncontrolled cognitive, emotional and behavior patterns,

including suicidal and/or self-harming behaviors. DBT was originally developed as a treatment for individuals with Borderline Personality Disorder (BPD). BPD is characterized by a range of self-destructive behaviors (potentially including self-injury, suicidality, substance use, as well as problems in interpersonal relationships) which may be best understood as the consequences of the inability to effectively regulate emotions. These deficits are often the result of biological emotional sensitivity paired with an environment that was not responsive during childhood. Over the years, DBT has demonstrated effectiveness for a wide range of disorders, most of which are associated with difficulties in regulating emotions and associated cognitive and behavioral patterns. DBT is a research-based, empirically validated treatment delivered via four modalities – individual therapy, group skills training, telephone coaching and participation by DBT-trained providers in weekly 'Consultation Team' meetings. DBT is a model used within the service set for outpatient therapy by licensed practitioners.

- DBT was created for use with children, adolescents, and adults as a treatment for people with multiple, severe problems across multiple domains of functioning, which may include, but are not limited, to the following:
  - Borderline Personality Disorder;
  - Suicide and parasuicide;
  - Drug dependence;
  - Major drug dependence;
  - Opiate use;
  - Eating disorders;
  - Emotional dysregulation;
  - Impulsiveness;
  - Anger;
  - Interpersonal aggression; and
  - Trauma.
- DBT may require adaptation for use with individuals with a psychotic disorder; these individuals will need additional support or have their psychotic disorder symptoms well-managed concurrent with DBT.
- There is a sizable and growing body of literature demonstrating the effectiveness of DBT in persons with mild or moderate intellectual disabilities and in persons with Autism Spectrum Disorders (ASDs). With adaptations, DBT shall be considered as a legitimate therapy option for persons with intellectual disabilities.

Service Delivery

- Comprehensive DBT addresses five components, or functions, of treatment:
  - Capability enhancement (skills training);
  - Motivational enhancement (individual behavioral treatment plans);
  - Generalization (access to therapist outside clinical setting, homework, and inclusion of family in treatment);
  - Structuring of the environment (programmatic emphasis on reinforcement of adaptive behaviors); and
  - Capability and motivational enhancement of therapists (therapist team consultation group).
- DBT emphasizes balancing behavioral change, problem-solving, and emotional regulation with validation, mindfulness, and acceptance of clients.
- DBT targets these behaviors in the service of achieving DBT's main goal, which is defined as the individual in treatment creating "a life worth living." Behaviors targeted in individual therapy sessions are as follows:
  - Eliminate life-threatening behavior;
  - Reduce therapy-interfering behavior;
  - Reduce quality of life-interfering behavior; and
  - Increase behavioral skills.
- The DBT program ensures there is a designated DBT primary therapist (usually the client's individual therapist) for each beneficiary. The DBT Team follows the Linehan model in the provision of DBT services which consists of:
  - Individual therapy with a DBT-trained therapist

        - An individual therapy session, typically provided for one hour per week, would include the clinician and client. Portions of a session may include important members who support the client (caregivers, other providers), as needed. These sessions focus on engagement, motivation, assessment, and tailoring of cognitive- behavioral strategies to each client. Clients are taught how to identify and measure progress toward goals, assess problems, and solve problems within sessions. The individual therapist is available to clients outside of session times, to motivate and coach clients, avoid higher levels of care, and achieve generalization of skills into everyday life.
    - DBT skills training group
        - A DBT skills training group is a 120-150-minute session held weekly in a group format, with all clients participating in comprehensive DBT. Group time is divided in half, with an hour to review homework from the past week, and an hour to teach new skills and assign homework for the next week. There is often a short break between the hours, if they are taught consecutively. Group is led by two co-leaders, who each have separate roles to perform. Groups are limited in size to enable the group to function well and to allow each client to share about their homework every week. DBT experts suggest that DBT skills-training groups are most effective with at least two participants; there is no strict maximum number of clients in a DBT skills training group but keeping the group to 12 or fewer participants is good practice. The focus of group is to teach new skills to address potential client deficits in the areas of mindfulness, relationships, emotion regulation, and crisis management. Handouts are provided to clients, and these plus the lecture points to be covered are found in manuals published by Linehan for adults and Rathus and Miller and Linehan for adolescents.
        - For the treatment of adolescents, it is highly recommended that the skills training group be a multifamily skills training group, to include as active participants both the adolescent and their caregiver(s). In the multifamily group format, caregivers learn and practice skills alongside their adolescent, helping caregivers to be better able to support the youth as they apply DBT strategies to their daily lives, and also allows caregivers to learn skills for their own use managing difficult emotions in interactions with their adolescent. The caregiver participating with their adolescent in the multifamily group, must be the same caregiver to participate throughout the duration of the group. In the case of a multifamily group with both adolescent and caregiver participation, a recommended best practice is to keep the group to seven (7) or fewer adolescent participants, each with one caregiver participating as well.
    - Telephonic, therapeutic coaching (24-hour availability)
        - A DBT program professional, usually the client's individual therapist, is available by telephone to each client to extend problem-solving and coach the use of skills in real-world situations. DBT coaching is not therapy, but instead is brief, targeted, and specific support, aimed to help the DBT client generalize skillful behavior in all relevant contexts. Coaching may be conducted via text message. The amount and type of coaching may be tailored to meet individual client needs, and may include planned, proactive check-ins, and/or being available to the client in the midst of a crisis. If the coaching is provided by a professional who is not the client's primary therapist (for instance, if coaching is provided by agency staff who rotate in availability for after-hours coverage), then the coaching response shall follow guidance from a detailed, client-specific DBT crisis plan completed by the client's individual therapist.
- Recommended Intensity
    - Individual sessions are recommended for one hour per week; and
    - Group therapy sessions are 120-to-150-minute weekly sessions in a group format.
- Recommended Duration
    - A course of DBT treatment is typically completed in 6-12 months but may be extended for additional 6-month time periods; the duration of treatment will vary based on the extent and complexity of need.
    - If MCO policy requires prior authorization for outpatient therapy by licensed providers, including treatment episodes of DBT:

- The provider requesting prior authorization must note that the evidence-based model DBT is being used. An initial authorization to cover a 6-month episode of treatment is recommended so that the provider may complete the medically necessary treatment episode and provide evidence-based care to the individual. A typical 6-month episode of treatment may include:
  - Individual therapy sessions: 4 pre-treatment sessions, 24-25 treatment sessions, 3-4 termination sessions; and
  - DBT skills training group (group therapy): 24-25 sessions.
- If additional sessions beyond the initial authorization are needed to complete a treatment episode of DBT, the re-authorization request must indicate that the

- Delivery Setting
  - As an outpatient therapy service delivered by licensed practitioners, allowed modes of delivery include individual, family, group, on-site, off-site, and tele-video. Telehealth delivery is allowed if it includes synchronous, interactive, real-time electronic communication comprising both audio and visual elements.
  - A comprehensive DBT program is typically provided in an outpatient setting. Telehealth is an allowed modality, and use of telehealth for DBT skills training groups in particular may support continued and consistent client engagement, especially when travel or transportation is a barrier to client engagement.
  - Components of DBT may be delivered, with some adaptation, in a residential or inpatient setting; however, this would not be billed as a separate service, instead would be part of the active treatment plan reimbursed as part of the comprehensive inpatient or psychiatric residential treatment facility (PRTF) rate.
- Cultural Considerations
  - DBT has been demonstrated to work across numerous populations and is amenable to cultural adaptations. DBT has been evaluated and found to be effective with individuals from diverse backgrounds in regard to age, gender, sexual orientation, and ethnicity, including children (seven- to twelve-year-olds) and adolescents (twelve- to eighteen-year-olds). DBT was originally developed in the United States but has since been researched and evaluated around the world, including randomized control trials in Australia, Europe, South America, and Asia. Research trials have shown that DBT can be implemented effectively across cultures.
- Provider Qualifications and Responsibilities
  - Staff Qualifications

    Delivery of the comprehensive DBT model requires a team, preferably with 4-6 clinicians trained and qualified to provide DBT individual therapy;
    - DBT teams may be comprised of LMHP clinicians or may be comprised of a mix of LMHP clinicians alongside other qualified practitioners, which may include staff licensed as a Provisionally Licensed Professional Counselor (PLPC), Provisionally Licensed Marriage and Family Therapist (PLMFT), or Licensed Master Social Worker (LMSW). For DBT teams comprised of a mix of LMHPs and other qualified practitioners, there must be a minimum of two (2) LMHPs on the DBT team. Other qualified practitioners may serve as a co-leader for a DBT skills training groups, alongside an LMHP co-leader.
  - Staff Supervision for Non-LMHP Staff
    - Provisionally Licensed Professional Counselor (PLPC), Provisionally Licensed Marriage and Family Therapist (PLMFT), or Licensed Master Social Worker (LMSW) delivering DBT 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 provider agency employing these staff. For the psychology intern, the supervisory plan is acceptable[HR11].

  - EBP Model Requirements: To be considered a comprehensive DBT program with fidelity to the evidence-based model, DBT must be delivered by a team of clinicians, and must include the following four (4) core components:
    - Individual therapy with a DBT-trained therapist: Typically provided for one hour per week, face-to-face (including telehealth) with an LMHP clinician and client;

        - Telephonic, therapeutic consultation/support/coaching (24-hour availability): A DBT program professional, usually the individual therapist, is available by telephone to each client at all times during the week, to extend problem-solving and coach skills to be used in real-world situations;
        - DBT skills training group: Typically, 120-150-minute session held weekly in a group format, with all clients participating. Group is led by two co-leaders ~~a leader and co-leader~~. For the treatment of adolescents, it is highly recommended that the skills training group be a multifamily skills training group, to include as active participants both the adolescent and a caregiver; and
        - Peer consultation team meetings: Each DBT team member (individual therapist, skills group co-leaders ~~and co-leader~~) participates in a weekly, one-hour consultation team meeting with other DBT practitioners [HR12]in the same program. Teams are small enough that each provider can provide an agenda item most weeks. The hour-long meeting is used for peer consultation, following DBT model guidelines. The team may meet for a second hour, to be used to provide training to providers, where necessary. This format can be run consecutively or as two separate meetings in a week.
- Allowed Provider Types and Specialties
    - PT 31 Psychologist PS:
        - 6A Psychologist - Clinical;
        - 6B Psychologist - Counseling;
        - 6C Psychologist - School;
        - 6D Psychologist - Developmental;
        - 6E Psychologist - Non-declared;
        - 6F Psychologist - Other; and
        - 6G Psychologist - Medical.
    - PT 73 Social Worker (Licensed/Clinical) PS 73 Social Worker;
    - PT AK Licensed Professional Counselor (LPC) PS 8E LPC;
    - PT AH Licensed Marriage & Family Therapists (LMFT) PS 8E;
    - PT AJ Licensed Addiction Counselor PS 8E CSoC/Behavioral Health;
    - PT 19 Doctor of Osteopathic Medicine PS:
        - 26 Psychiatry;
        - 27 Psychiatry; Neurology; and
        - 2W Addiction Specialist.
    - PT 20 Psychiatrist PS:
        - 26 Psychiatry; and
        - 2W Addiction Specialist.
    - PT 78 Registered Nurse (APRN) PS 26; and
    - PT 93 Clinical Nurse Specialist (APRN) PS 26.
- Measuring Outcomes
    - Measuring the progress and outcomes of treatment is a critical aspect of DBT and is part of the evidence-based model. DBT typically uses a set of standard tools, for both adolescent and adult clients, all of which are open source and accessible to providers at no cost. Standard tools to measure the outcomes of treatment include:
        - Borderline Symptom List 23 (BSL 23): self-report measure of symptoms such as affective instability and recurrent suicidal/self-harming behavior;
        - Difficulties in Emotion Regulation Scale (DERS): self-report measure of emotion regulation problems; and
        - Ways of Coping Checklist: self-report measure of the individual's application of therapeutic skills to cope with stressful events.
    - Outcomes measures must be completed by DBT program clients at minimum pre- and post- treatment, and at least at six-month intervals. If a client is receiving a twelve (12)-month episode of care, it may be beneficial to schedule outcomes measurement at four (4) month intervals to better support progress tracking and treatment adjustments over the course of the episode of care.
    - Client-level data on outcomes metrics will be documented in the client's health record, interim measures of progress shall be documented in requests for continued service authorization, and pre/post measures included in documentation such as discharge summaries.

- DBT provider teams shall aggregate client outcome data at the program level and submit de- identified program-level aggregate outcomes data to all contracted MCOs (or their designee) semi- annually.

- Model-Specific Documentation Requirements
  - The DBT model does not prescribe a specific format for progress notes, however, use of the DBT model in therapy can be observed in a client's record by the presence of specific references in the progress note for each session:
    - Clients complete "Diary Cards" each week to bring to their individual therapy session. Data from client-completed diary cards is documented in the progress note for each session. This data on client symptoms and behaviors is then used to set the agenda for the session;
    - Agenda for the session, including the behavioral targets for the session;
    - In most sessions, reference to a DBT-specific assessment (chains, missing links, behavioral assessment) that is used to determine interventions; and
    - Reference to the intervention (i.e. cognitive modification, skills, contingency management, exposure, problem solving) used in the session, and what the client committed to doing for homework or in the future.
- Fidelity and the DBT Team
  - As a team-based model, fidelity to the DBT model is best assessed at the team/program level. A DBT program may demonstrate fidelity to the DBT model through delivery of specific program components, policies, and procedures. These include:
    - Team - Delivery of the comprehensive DBT model requires a team, preferably with 4-6 clinicians trained and qualified to provide DBT individual therapy, and each qualified clinician carrying a caseload of at least 2-3 clients for DBT individual therapy. A DBT team of two DBT-trained and-qualified clinicians is the minimum to maintain qualification as a DBT program; the status of having only two qualified clinicians on a DBT team shall be considered temporary while the team works to replace team members and coordinate replacement training for new team members, to build back up to a full DBT team;
    - Training - All DBT team members providing DBT individual therapy must be trained and qualified to provide DBT; please see "Training" in this section for requirements:
      - A qualified DBT team may add new team members (based on need for expansion of services, and/or need to replace practitioners due to staff attrition) initially by allowing new DBT team members to begin co-leading skills training group prior to completing DBT didactic training, as long as:
        - The primary skills training group co-leader has completed DBT training; and
        - The new team member completes DBT training within 6 months of starting to co-lead DBT skills training groups.
      - A qualified DBT team may add new team members providing DBT individual therapy after the new team member has completed initial DBT didactic training.
    - Individual therapy, delivered weekly by a DBT trained clinician;
    - DBT skills training groups, held weekly with two clinician co-leaders;
    - Peer consultation group with all team members, held weekly, facilitated by the lead clinician from the DBT team. Consultation group with team members addresses group functioning, planning, and dynamics, in the therapy group; and
    - Telephonic, therapeutic coaching with 24-hour availability to each client.
  - Annually following completion of DBT training and qualification, the DBT program will complete a self-assessment of program fidelity using an OBH-approved process adapted from the DBT-LBC Program Certification Self-Assessment. The DBT program shall use this self- assessment process to review and if needed revise policies and practices, including implementing a corrective action plan as needed for improved alignment with best practices. The self- assessment, and if applicable the corrective action plan, shall be made available at the request of OBH or LDH-contracted managed care organizations.
  - Following completion of DBT training and qualification, qualified DBT programs will be externally-reviewed for DBT program fidelity on a regular basis, using an OBH-

approved process adapted from the DBT-LBC Program Certification Self-Assessment and inclusive of practitioner completion of DBT continuing education. DBT program fidelity reviews will be completed at a frequency of every 2 years following DBT program qualification. Fidelity reviews may be requested at a higher frequency if issues are identified that trigger additional review.

- Billing
  - A DBT practitioner may receive reimbursement for the DBT service, when delivering DBT as part of a DBT team that is:
  - Trained and qualified to deliver DBT as demonstrated by either:
    - Certification from the DBT-Linehan Board of Certification (DBT-LBC);
    - OBH-approved DBT qualification; or
    - Engaged consistently and in good standing (as documented in writing by the OBH-sponsored training organization) in an OBH-sponsored DBT training program that will lead to an OBH-approved DBT qualification, following the agency and practitioner's completion of the initial didactic training sessions, while under consultation with an OBH-approved DBT trainer.
  - Following initial qualification to deliver DBT, the team also must complete periodic fidelity reviews; please refer to the "Fidelity" section;
  - Only direct staff face-to-face time with the individual or family may be billed. DBT is a face-to-face intervention with the individual present. Telehealth delivery is allowed if it includes synchronous, interactive, real-time electronic communication comprising both audio and visual elements. Services provided using telehealth must be identified on claims submission 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;[HR13]
  - The DBT model is delivered in three (3) modalities:
    - Individual therapy;
    - DBT skills training group sessions; and
    - Therapeutic coaching (24-hour availability) not billed.
  - The group therapy session must be co-led by two (2) DBT practitioners, and must be delivered for a minimum of 90 minutes; in standard practice the DBT skills training group typically has a duration of 120-150 minutes; and
    For DBT skills training groups which are co-led by two practitioners, one practitioner submits the group therapy claim for a client, with progress notes to be co-signed by both of the group co-leaders. The co-leader who submits the group therapy claim, must be an LMHP, and the co-leader who does not submit the claim, may be another qualified practitioner. [HR14]All standard record-keeping requirements must be met, including recording start and end time of service. The co-leader of the DBT skills training group who does not submit the claim, may not have completed the DBT qualification, but must complete initial DBT didactic training within six (6) months of beginning to co-lead DBT skills training groups.

Multisystemic Therapy

Multisystemic Therapy (MST) provides an intensive home/family and community-based treatment for youth who are at risk of out-of-home placement or who are returning from out-of-home placement. The MST model is based on empirical data and evidence-based interventions that target specific behaviors with individualized behavioral interventions. Services are primarily provided in the home, but workers also intervene at school and in other community settings. All MST services must be provided to, or directed exclusively toward, the treatment of the Medicaid-eligible youth. MST services are targeted for youth primarily demonstrating externalizing behaviors, such as conduct disorder, antisocial or illegal behavior or acts that lead to costly and, oftentimes, ineffective out-of-home services or excessive use of child-focused therapeutic support services. Depression and other disorders are considered, as long as the existing mental and BH issues manifest in outward behaviors that impact multiple systems (i.e., family, school, community). Youth with substance use issues may be included if they meet the criteria below, and MST is deemed clinically more appropriate than focused drug and alcohol treatment.

Admission Criteria

- The member is 12-17 years old.
- ~~AND~~
- The member exhibits significant externalizing behavior, such as chronic or violent juvenile offenses.
- ~~AND~~
- The member is at risk for out-of-home placement or is transitioning back from an out-of-home setting.
- ~~AND~~
- The member has externalizing behaviors and symptomatology resulting in a DSM-5 diagnosis of Conduct Disorder or other diagnoses consistent with such symptomatology.
- ~~AN~~D
- There is ongoing multiple system involvement due to high-risk behaviors and/or risk of failure in mainstream school settings due to behavioral problems.
- ~~AND~~
- Less intensive treatment has been ineffective or is inappropriate; or
- The member's treatment planning team or **Child Family Team** (CFT) recommends that ~~he/she~~ **they** participate in MST.

Continuing Stay Criteria

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

Discharge Criteria

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

Service Delivery

- MST services may not be clinically appropriate for individuals who meet the following conditions:
  - Members who meet the criteria for out-of-home placement due to suicidal, homicidal or psychotic behavior.

- Members living independently or members whom a primary caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends or other potential surrogate caregivers.
- The referral problem is limited to serious sexual misbehavior in the absence of other delinquent or antisocial behavior.
- Youth with moderate to severe difficulties with social communication, social interaction, and repetitive behaviors, which may be captured by a diagnosis of autism;
- Low-level need cases; or
- Members who have previously received MST services or other intensive family- and community-based treatment.

- **Exceptions may be allowed an additional course of treatment if all of the following criteria are met:**
  - **MST program eligibility criteria are currently met;**
  - **Specific conditions have been identified that have changed in the youth's ecology, compared to the first course of treatment;**
  - **It is reasonably expected that successful outcomes could be obtained with a second course of treatment; and**
  - **Program entrance is subject to prior authorization by the managed care organization (MCO).**

- **Specific Design of the Service**
  - **On average, a youth receives MST for 3 to 5 months, but typically, no longer than five months. The therapist meets with the youth or family at least weekly but often multiple times per week, depending on need. Families typically see therapists less frequently as they get closer to discharge. On average, families receive about 60 hours of face-to-face treatment over a four-month period, as well as about 35 hours of non-direct contact provided to the ecology of the youth (e.g., consultation and collaboration with other systems). (Please note that these contact hours reflect averages only and are not intended to specify a set number of family or member contacts. The MST model is intended to be a highly individualized treatment that is intensive and is delivered as frequently as is required to produce the outcomes desired for each specific youth). Services occur in the family's home or community at times that are convenient for the family. Staff members are expected to work on weekends and evenings, for the convenience of their members. Therapists and/or their supervisors are on call for families 24/7. Supervisors are available to therapists around-the-clock for support. Each therapist carries a small caseload (four to six families) at any one time.**
  - **MST includes the following:**
    - **Assessment;**
    - **Ongoing treatment planning;**
    - **Family therapy;**
    - **Parent counseling (related to empowering caregivers to parent effectively and address issues that pose barriers to treatment goals);**
    - **Consultation to and collaboration with other systems, such as school, juvenile probation, children and youth and job supervisors;**
    - **Individual therapy may occur but is not the primary mode of treatment; and**
    - **Referral for psychological assessment, psychiatric evaluation and medication management, if needed.**
    - **NOTE: The term "counseling" throughout the MST section is in keeping with the nomenclature of this evidenced based practice and should not be mistaken for the counseling and psychotherapy rendered by licensed mental health professionals (LMHPs) under their respective scope of practice license.**
  - **Unless it directly impacts the youth's treatment, MST therapists do not provide individual therapy to caregivers or other family members, or marital therapy.**

Exclusions

- MST services are comprehensive of all other services, with the exception of psychological evaluation or assessment and medication management.

- MST shall not be billed in conjunction with residential services, including professional resource family care.

Outpatient Therapy Services

Outpatient Therapy Services are assessment and diagnosis and active behavioral health treatment that are provided in an ambulatory setting. The course of treatment in Outpatient is focused on addressing the factors that precipitated admission (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the factors that precipitated admission no longer require treatment.

Admission Criteria

- All Medicaid-eligible children and adults that meet medical necessity criteria.

Service Delivery

- Allowed modes of service are individual, family, group, on-site, off-site, and tele-video.
- ~~When covered,~~ Licensed Practitioner Outpatient Therapy includes:
  - Outpatient psychotherapy (individual, family and group);
  - Psychotherapy for crisis;
  - Psychoanalysis;
  - Electroconvulsive therapy;
  - Biofeedback;
  - Hypnotherapy;
  - Screening, assessment, examination, and testing;
  - Diagnostic evaluation;
  - Medication management; and
  - Case conference* (CSoC only).
- An LMHP is an individual licensed in the State of Louisiana to diagnose and treat mental illness or substance use, acting within the scope of all applicable State laws and their professional license.
  - An LMHP includes the following individuals who are licensed to practice independently:
    - Medical psychologists;
    - Licensed psychologists;
    - Licensed clinical social workers (LCSWs);
    - Licensed professional counselors (LPCs);
    - Licensed marriage and family therapists (LMFTs);
    - Licensed addiction counselors (LACs); and
    - Advanced practice registered nurses (APRNs).
  - Physicians must be a psychiatrist or physician's assistant working under protocol of a psychiatrist to deliver these services.
  - Services provided to children and youth must include communication and coordination with the family and/or legal guardian, as well as the primary care physician (PCP). Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the youth's treatment record.
  - Psychological testing must be prior authorized by the MCO.
  - 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.

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:
  - 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);
  - 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 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~~
  - ~~Providers must deliver in-person services when telehealth is not clinically appropriate or when the member requests in-person services.~~
  - **Group psychotherapy is only allowed via telehealth when utilized for Dialectical Behavioral Therapy (DBT) and must include synchronous, interactive, real-time electronic communication comprising of both audio and visual elements.**

Peer Support Services

Peer Support Services (PSS) are an evidence-based behavioral health service that consists of a qualified peer support provider, who assists members with their recovery from mental illness and/or substance use. The PSS are provided by Recognized Peer Support Specialists (RPSS), who are individuals with personal lived experience with recovery from behavioral health conditions and successfully navigating the behavioral health services system. PSS are behavioral health rehabilitative services to reduce the disabling effects of an illness or disability and restore the member to the best possible functional level in the community. PSS are person-centered and recovery focused. PSS are face-to-face interventions with the member present. Most contacts occur in community locations where the member lives, works, attends school and/or socializes.

Peer Support Services, or Consumer Operated Services, are recognized by SAMHSA as an Evidence-Based Practice. PSS are designed on the principles of individual choice and the active involvement of members in their own recovery process. Peer support practice is guided by the belief that people with mental illness and/or substance use disorders need opportunities to identify and choose for themselves their desired roles with regard to living, learning, working and social interaction in the community.

Admission Criteria

- The member is 21 years of age or older; and
- The member has 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:
  - Be currently receiving PSH services; or
  - Have been transitioned from a nursing facility or been diverted from nursing facility level of care through the My Choice Louisiana program.

Service Delivery

- **Services are subject to prior authorization. Allowed modes of delivery are individual, group, on-site, and off-site.**
- PSS include a range of tasks to assist the member during the recovery process. Recovery planning assists members to set and accomplish goals related to home, work, community and health. PSS may include, but are not limited to:
  - Utilizing 'lived experience' to translate and explain the recovery process step by step and expectations of services;
  - Assisting in the clinical process through:
    - Providing feedback to the treatment team regarding identified needs of the member and the level of engagement of the member;
    - Development of goals;
    - Acting as an advocate, with the permission of the member, in the therapeutic alliance between the provider and the member;
    - Encouraging a member with a low level of engagement to become actively involved in treatment; and
    - Ensuring that the member is receiving the appropriate services of their choice and in a manner consistent with confidentiality regulations and professional standards of care.
  - Rebuilding, practicing, and reinforcing skills necessary to assist in the restoration of the member's health and functioning throughout the treatment process;
  - Providing support to the member to assist them with participation and engagement in meetings and appointments;
  - Assisting the members in effectively contributing to planning and accessing services to aid in the member's recovery process;
  - Aiding the member in identifying and overcoming barriers to treatment and support member in communicating these barriers to treatment and service providers;
  - Assisting the member with supporting strategies for symptom/behavior management;
  - Supporting the member to better understand their diagnoses and related symptoms;
  - Assisting the member with finding and using effective psychoeducational materials;
  - Assisting the member to identify and practice self-care behaviors, including but not limited to developing a wellness recovery plan and relapse prevention planning;
  - Explaining service and treatment options;
  - Assisting the member to develop support systems with family and community members:
    - Serving as an advocate, mentor, or facilitator for resolution of personal issues and reinforcement of skills necessary to enhance and improve the member's health;
    - Fostering the member in setting goals, promoting effective skills building for overall health, safety and wellbeing that support whole health improvements and
      - achievements of identified goals and healthy choices;
      - Functioning as part of the member's clinical team to support the principles of self-direction to:
        - Assist and support the member to set goals and plan for the future;
        - Propose strategies to help the member accomplish tasks or goals; and
        - Support the member to use decision-making strategies when choosing services and supports; and

        - Providing support necessary to ensure the member's engagement and active participation in the treatment planning process.
    - Supporting the member to arrange services that will assist them to meet their treatment plan goals, inclusive of identifying providers such as:
        - primary care services;
        - behavioral health management and treatment services;
        - local housing support programs;
        - supportive employment;
        - education, other supportive services;
        - referral to other benefit programs; and
        - arranging non-emergency medical transportation.
    - Providing support with transitioning members from a nursing facility and adjustment to community living.
    - 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 member receiving services;
        - Appropriate to members of diverse racial, ethnic, religious, sexual and gender identities and other cultural and linguistic groups; and
        - Appropriate for age, development, and education.
- 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.
- Supervision with Licensed Mental Health Professional (LMHP):
    - The supervision with the LMHP must be documented. Documentation should reflect the content of the training and/or clinical guidance. The documentation must include the following:
        - 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;
        - Focus of the session and subsequent actions that the supervisee/s 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/or PSS topics addressed; and
        - Start and end time of each supervision session.

Limitations/Exclusions

- The following services shall be excluded from Medicaid coverage and reimbursement:
    - Services that are purely recreational, social or leisure in nature, or have no therapeutic or programmatic content;
    - Peer support services that are provided to members as an integral part of another covered Medicaid service;
    - Transportation;
    - General office/clerical tasks; and
    - Attendance in meetings or sessions without a documented purpose/benefit from the peer's presence in that meeting or session.

Personal Care Services

Personal care services (PCS) include assistance and/or supervision necessary for members with mental illness to enable them to accomplish routine tasks and live independently in their own homes.

Admission Criteria

- Medicaid eligible members who meet medical necessity criteria may receive PCS when recommended by the member's treating licensed mental health professional (LMHP) or physician within their scope of practice.
- Members must be at least 21 years of age and have transitioned from a nursing facility or been diverted from nursing facility level of care **or been diverted from nursing facility level of care through the My Choice Louisiana program.**
- Members must be medically stable, not enrolled **or eligible for** a Medicaid-funded program which offers a personal care service or related benefit, **including Long Term Personal Care Services (LT-PCS),** and whose care needs do not exceed that which can be provided under the scope and/or service limitations of this personal care service.

Discharge Criteria

- If the provider proposes involuntary transfer, discharge of a member, or if a provider closes in accordance with licensing standards, the following steps must be taken:
  - The provider shall give written notice to the member, a family member and/or the authorized representative, if known, and the case manager, if applicable, at least 30 calendar days prior to the transfer or the discharge;
  - Written notice shall be made via certified mail, return receipt requested and shall be in a language and manner that the member understands;
  - A copy of the written discharge/transfer notice shall be put in the member's record;
  - When the safety or health of members or provider staff is endangered, written notice shall be given as soon as possible before the transfer or discharge to the member, a family member and/or the authorized representative, if known, and the case manager;
  - The written notice shall include the following:
    - A reason for the transfer or discharge;
    - The effective date of the transfer or discharge;
    - An explanation of a member's right to personal and/or third parties' representation at all stages of the transfer or discharge process;
    - Contact information for the Advocacy Center;
    - Names of provider personnel available to assist the member and family in decision making and transfer arrangements;
    - The date, time and place for the discharge planning conference;
    - A statement regarding the member's appeal rights;
    - The name of the director, current address and telephone number of the Division of Administrative Law; and
    - A statement regarding the member's right to remain with the provider and not be transferred or discharged if an appeal is timely filed.
- Provider transfer or discharge responsibilities shall include:
  - Holding a transfer or discharge planning conference with the member, family, case manager (if applicable), legal representative and advocate, if such is known;
  - Developing discharge options that will provide reasonable assurance that the member will be transferred or discharge to a setting that can be expected to meet his/her needs;
  - Preparing an updated service plan, as applicable, and preparing a written discharge summary that shall include, at a minimum, a summary of the health, behavioral issues, social issues and nutritional status of the member; and
  - Providing all services required prior to discharge that are contained in the final update of the service plan, as applicable, and in the transfer or discharge plan.

Service Delivery

- Personal care services include the following:

- Minimal assistance with, supervision of, or prompting the member to perform activities of daily living (ADLs) including eating, bathing, grooming/personal hygiene, dressing, transferring, ambulation, and toileting.
- Assistance with, or supervision of, instrumental activities of daily living (IADLs) to meet the direct needs of the member (and not the needs of the member's household), which includes:
  - Light housekeeping, including ensuring pathways are free from obstructions;
  - Laundry of the member's bedding and clothing, including ironing;
  - Food preparation and storage;
  - Assistance with scheduling (making contacts and coordinating) medical appointments;
  - Assistance with arranging transportation depending on the needs and preferences of the member;
  - Accompanying the member to medical and behavioral health appointments and providing assistance throughout the appointment;
  - Accompanying the member to community activities and providing assistance throughout the activity;
  - Brief occasional trips outside the home by the direct service worker on behalf of the member (without the member present) to include shopping to meet the health care or nutritional needs of the member or payment of bills if no other arrangements are possible and/or the member's condition significantly limits participation in these activities; and
  - Medication reminders with self-administered prescription and non-prescription medication that is limited to:
    - Verbal reminders;
    - Assistance with opening the bottle or bubble pack when requested by the member;
    - Reading the directions from the label;
    - Checking the dosage according to the label directions; or
    - Assistance with ordering medication from the drug store.
      - NOTE: PCS workers are NOT permitted to give medication to members. This includes taking medication out of the bottle to set up pill organizers.

- Assistance with performing basic therapeutic physical health interventions to increase functional abilities for maximum independence in performing activities of daily living, such as range of motion exercise, as instructed by licensed physical or occupational therapists, or by a registered nurse.
- There shall be member involvement throughout the planning and delivery of services. Services shall be:
  - Delivered in a culturally and linguistically competent manner in accordance with member's preferences and needs;
  - Respectful of the member receiving services;
  - Appropriate to members of diverse racial, ethnic, religious, sexual and gender identities and other cultural and linguistic groups; and
  - Appropriate for age, development, and education.
- Providers must develop a service plan in collaboration with the member/member's family to include the specific activities to be performed, including frequency and anticipated/estimated duration of each activity, based on the member's goals, preferences, and assessed needs. The service plan must be developed prior to service delivery and updated at least every six (6) months, or more frequently based on changes to the member's needs or preferences. The PCS provider shall provide the plan to the member prior to service delivery and when the plan is updated.
- **Services require 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.**
- **Services are limited to 20 hours per week. An exception may be made by the MCO Medical Director to exceed this limit with documentation that services are medically necessary and the member does not qualify for PCS under another Medicaid-funded program.**
- **The weekly limit does not include the per diem rate, which is to be used for temporary, time limited events in which a member may need additional assistance, such**

as following a member's hospitalization. The per diem rate shall not exceed 30 calendar days in a one-year period.

Limitations/Exclusions

- PCS does not include administration of medication; insertion and sterile irrigation of catheters; irrigation of any body cavities which require sterile procedures; complex wound care; or skilled nursing services as defined in the State Nurse Practice Act.
- Services must be provided in home and community-based settings, and may not be provided in the following settings:
  - In a home or property owned, operated, or controlled by an owner, operator, agent, or employee of a licensed provider of personal care services.
  - In the direct service worker's home.
  - In a nursing facility, Intermediate Care Facility for the Developmentally Disabled, Institute for Mental Disease, or other licensed congregate setting.
- There shall be no duplication of services.
  - PCS may not be provided while the member is attending or admitted to a program or setting that provides in-home assistance with ADLs or IADLs or while attending or admitted to a program or setting where such assistance is provided.
  - IADLs may not be performed in the member's home when the member is absent from the home. Exceptions may be approved by the Medicaid managed care medical director on a case-by-case, time-limited basis.
  - PCS may not be billed during the time the member has been admitted to a hospital, nursing home, or residential facility. Services may be provided and billed on the day the member is admitted to the hospital and following the member's discharge.
- PCS shall not supplant care provided by natural supports.
- PCS does not include room and board, maintenance, upkeep, and/or improvement of the member's or family's residence.
- PCS may not be provided outside the state of Louisiana unless a temporary exception has been approved by the Medicaid managed care entity.
- Direct service workers may not work more than 16 hours in a 24-hour period.
- The following individuals are prohibited from being reimbursed for providing services to a member:
  - Biological, legal or step first-, second-, third- or fourth-degree relatives.
  - First-degree relatives include parents, spouses, siblings, and children.
  - Second-degree relatives include grandparents, grandchildren, aunts, uncles, nephews, and nieces.
  - Third-degree relatives include great-grandparents, great-grandchildren, great aunts, great uncles, and first cousins.
  - Fourth-degree relatives include great-great grandparents, great-great grandchildren, and children of first cousins.
  - Curator, tutor, legal guardian, authorized representative, and any individual who has power of attorney.
- **The service unit is 15 minutes and is reimbursed at a flat rate, with the exception of the per diem rate for which the unit is a per day rate. The per diem rate is to be used for temporary, time-limited events when the member needs additional assistance, such as following a member's hospitalization. The per diem rate shall not exceed 30 non-consecutive calendar days in a one-year period;**
- **Reimbursement for services may be withheld or denied if the provider fails to use the electronic visit verification (EVV) system or does not use the system in compliance with LDH's policies and procedures for EVV; and**
  Transportation is not a required component of PCS although providers may choose to furnish transportation for members during the course of providing PCS. If transportation is furnished, the provider must accept all liability for their employee/direct service worker transporting a member. It is the responsibility of the provider to ensure the employee/DSW has a current, valid driver's license, automobile liability insurance, and pass a motor vehicle screen prior to transporting members.

Psychiatric residential treatment facilities (PRTFs) are non-hospital facilities offering intensive inpatient services to individuals under the age of 21 who have various behavioral health issues. PRTFs are required to ensure that all medical, psychological, social, behavioral and developmental aspects of the member's situation are assessed and that treatment for those needs are reflected in the plan of care (POC) per 42 CFR 441.155. In addition to services provided by and in the facility, when they can be reasonably anticipated on the active treatment plan, the PRTF must ensure that the member receives all treatment identified on the active treatment plan and any other medically necessary care required for all medical, psychological, social, behavioral and developmental aspects of the member's situation.

Admission Criteria

- Children under 21 years of age, pre-certified by an independent team, where:
  - Ambulatory care resources available in the community do not meet the member's treatment needs;
  - Proper treatment of the member's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
  - The services can be reasonably expected to improve the member's condition or prevent further regression, so that the services will no longer be needed;
- The independent team pre-certifying the PRTF stay must:
  - Include a physician;
  - Have competence in diagnosis and treatment of mental illness, preferably in child psychiatry; and
  - Have knowledge of the individual's situation.

Service Delivery

- Services must meet active treatment requirements, which means implementation of a professionally developed and supervised individual POC that is developed and implemented no later than 72 hours after admission and designed to achieve the recipient's discharge from inpatient status at the earliest possible time. "Individual POC" means a written plan developed for each member to improve his condition to the extent that inpatient care is no longer necessary.
- The POC will:
  - Be based on a diagnostic evaluation conducted within the first 24 hours of admission in consultation with the youth and the parents/legal guardian that includes examination of the medical, psychological, social, behavioral and developmental aspects of the recipient's situation and reflects the need for inpatient psychiatric care;
  - Be developed by a team of professionals in consultation with the child and the parents, legal guardians or others in whose care the youth will be released after discharge;
  - State treatment objectives;
  - Prescribe an integrated program of therapies, activities and experiences designed to meet the objectives; and
  - Include, at an appropriate time, post-discharge plans and coordination of inpatient services, with partial discharge plans and related community services to ensure continuity of care with the member's family, school and community upon discharge.
- The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to:
  - Determine that services being provided are or were required on an inpatient basis;
  - and
  - Recommend changes in the plan, as indicated by the member's overall adjustment as an inpatient.

- Children/adolescents receiving services in a PRTF program must have access to education services, including supports to attend public school if possible, or in-house educational components, or vocational components if serving adolescents.
- The facility treatment team develops and reviews the individual POC. The individual POC must be developed by an interdisciplinary team of physicians and other personnel who are employed by, or provide services to, patients in the facility. Based on education and experience, preferably including competence in child psychiatry, the team must be capable of:
  - Assessing the beneficiary's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities;
  - Assessing the potential resources of the beneficiary's family;
  - Setting treatment objectives; and
  - Prescribing therapeutic modalities to achieve the plan's objectives.

Limitations and Exclusions

- The PRTF is compliant with seclusion and restraint requirements **per the LAC 48:I.Chapter 90 and 42 CFR 483 subpart G.**
- Reasonable activities include PRTF treatment provided by and in the facility when it was found, during the initial evaluation or subsequent reviews, to be treatment necessary to address a medical, psychological, social, behavioral or developmental aspect of the child's care.
- The PRTF reasonable activities are child-specific and necessary for the health and maintenance of health of the child while he or she is a resident of the facility.
- Medically necessary care constitutes a need that contributes to the inpatient treatment of the child and is dependent upon the expected length of stay of the particular child in that facility (e.g., dental hygiene may be necessary for a child expected to reside in the facility for 12 months but not 30 days).
  - Educational/vocational expenses are not Medicaid expenses. In addition, supports to attend public school outside of the PRTF are not considered activities provided by and in the PRTF and on the active treatment plan, and may not be reimbursed by Medicaid. However, supports to attend inhouse education/vocational components may be reimbursed by the PRTF utilizing Medicaid funding to the extent that it is therapy to support education in a PRTF (e.g., occupational therapy (OT), physical therapy (PT), speech therapy (ST), etc.). Medicaid funding for the education itself is not permitted. Medicaid will pay for the therapies associated with the education provided inhouse while the child is in a PRTF.

Therapeutic Group Home

Therapeutic Group Home (TGH) Children and Adolescents: A Therapeutic Group Home provides a community-based residential service in a home-like setting of no greater than 10 beds, **for members under the age of 21,** under the supervision and program oversight of a psychiatrist or psychologist. TGHs are located in residential communities in order to facilitate community integration through public education, recreation and maintenance of family connections. TGHs deliver an array of clinical and related services within the home, including psychiatric supports, integration with community resources and skill-building taught within the context of the home-like setting. The treatment should be targeted to support the restoration of adaptive and functional behaviors that will enable the child or adolescent to return to and remain successfully in his/her home and community, and to regularly attend and participate in work, school or training, at the child's best possible functional level.

Integration with community resources is an overarching goal of the TGH level of care, which is in part achieved through rules governing the location of the TGH facility, the physical space of the TGH facility, and the location of schooling for resident youth. The intention of the TGH level of care is to provide a 24-hour intensive treatment option for youth who need it, and to provide it in a location with more opportunities for community integration than can be found in other more restrictive residential placements (e.g.,

inpatient hospital or psychiatric residential treatment facility (PRTF)). To enhance community integration, TGH facilities must be located within a neighborhood in a community, must resemble a family home as much as possible, and resident youth must attend community schools integrated in the community (as opposed to being educated at a school located on the campus of an institution). This array of services, including psychiatric supports, therapeutic services (individual counseling, family therapy, and group therapy), and skill-building prepares the youth to return back to their community.

The setting shall be geographically situated to allow ongoing participation of the child's family. In this setting, the child or adolescent remains involved in community-based activities and attends a community educational, vocational program or other treatment setting.

Admission Criteria

- The medical necessity for 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. Less intensive levels of treatment must have been determined to be unsafe, unsuccessful or unavailable.
- The child under the age of 21 must require active treatment provided on a 24-hour basis with direct supervision/oversight by professional behavioral health staff that would not be able to be provided at a less restrictive level of care.
- The supervising practitioner should review the referral Pretreatment Assessment at admission or within 72 hours of admission and prior to service delivery.
- The member requires a twenty-four (24) hours/day, seven (7) days/week, structured and supportive living environment.
  - Although the psychologist or psychiatrist does not have to be on the premises when the member is receiving covered services, the supervising practitioner must assume accountability to direct the care of the member at the time of admission and during the entire TGH stay; and assure that the services are medically appropriate.
  - The psychiatrist or psychologist/medical psychologist must provide twenty-four (24) hour, on-call coverage seven (7) days a week.

Service Delivery: Assessment and Treatment Planning

- The supervising practitioner must complete an initial diagnostic assessment at admission or within seventy-two (72) hours of admission and prior to service delivery and must provide face to face assessment of the member at least every 28 days or more often as necessary;
- Assessments shall be completed with the involvement of the child or adolescent and the family and support system, to the extent possible.
- A standardized assessment and treatment planning tool must be used such as the Child and Adolescent Needs and Strengths (CANS) Comprehensive Assessment.
- The assessment protocol must differentiate across life domains, as well as risk and protective factors, sufficiently so that a treatment plan can be tailored to the areas related to the presenting problems of each youth and their family in order to ensure targeted treatment.
- Within seven days of admission, a comprehensive treatment plan shall be developed by the established multidisciplinary team of staff providing services for the member.
- Each treatment team member shall sign and indicate their attendance and involvement in the treatment team meeting. The treatment team review shall be directed and supervised by the supervising practitioner at a minimum of every 28 days.

Service Delivery: Treatment

- Treatment provided in the TGH or in the community should incorporate research-based approaches appropriate to the child's needs, whenever possible.
- The family/guardian should be involved in all aspects of treatment and face to face meetings as much as possible. Family members should be provided assistance with

transportation and video conferencing options to support their engagement with the treatment process.

- The individualized, strengths-based services and supports must:
  - Be identified in partnership with the child or adolescent and the family and support system, to the extent possible;
  - Be implemented with oversight from a licensed mental health professional (LMHP);
  - Be based on both clinical and functional assessments;
  - Assist with the development of skills for daily living, and support success in community settings, including home and school;
  - Focus on reducing the behavior and symptoms of the psychiatric disorder that necessitated the removal of the child or adolescent from his/her usual living situation;
  - Decrease problem behavior and increase developmentally appropriate, normative and pro-social behavior in children and adolescents who are in need of out-of-home placement. As much as possible, this work should be done with the engagement of, and in the context of the family with whom the youth will live next, such that the skills learned to increase pro-social behavior are practiced within family relationships and so can be expected to generalize to the youth's next living situation; and
  - Transition the child or adolescent from TGH to home- or community-based living, with outpatient treatment (e.g., individual and family therapy).
  - Care coordination is provided to plan and arrange access to a range of educational and therapeutic services.
  - Psychotropic medications should be used with specific target symptoms identification, with medical monitoring and 24-hour medical availability when appropriate and relevant.

Service Delivery: Discharge Planning

- Discharge planning begins on the day of admission using the TGH treatment episode to facilitate helping the youth progress towards be able to successfully reintegrate into a family setting. Discharge planning should be guided by the family/guardian and should identify, and coordinate aftercare services and supports that will help the youth maintain safe and healthy functioning in a family environment. **The discharge plan includes concrete plans for the child to transition back into the community beginning within the first week of admission with clear action steps and target dates outlined in the treatment plan. The treatment plan must include behaviorally measurable discharge goals.**

Service Exclusions

- Components that are not provided to or directed exclusively toward the treatment of the Medicaid eligible member;
- Services provided at a work site which are job tasks oriented and not directly related to the treatment of the member's needs;
- Any services or components in which the basic nature of which are to supplant housekeeping, homemaking, or basic services for the convenience of a member receiving substance use treatment services;
- Services rendered in an institution for mental disease (IMD);
- Room and board; and
- Supervision associated with the child's stay in the TGH.

In Lieu of Services

Freestanding psychiatric hospitals for adults ages 21-64

Requires prior authorization. The purpose of this ILOS is to assist adult enrollees with significant behavioral health challenges. This population is often treated in more expensive general hospital psychiatric units, which creates access issues as beds in this setting are limited. Individuals often remain in emergency departments while waiting for available beds, thereby increasing costs to the healthcare system as they utilize those

medical resources while awaiting beds in general hospitals. Use of freestanding psychiatric units reduces emergency department consumption, increases psychiatric bed capacity, and provides a less costly alternative to general hospital beds.

Integrated Behavioral Health Homes (IBHH)

Does not require prior authorization. Integrated Behavioral Health Homes (IBHH) is a value-based program that furthers alternative payment methodologies and integration by improving medical, behavioral, and social healthcare outcomes for participants while decreasing the overall total cost of care. MCOs who offer this ILOS will contract with qualified providers to deliver the six core services that are central to Medicaid health homes, as outlined by the ACA and endorsed by CMS, Substance Abuse and Mental Health Services Administration (SAMHSA), and the National Council for Mental Wellbeing:

- Comprehensive care management;
- Care coordination;
- Health promotion;
- Comprehensive transitional care and follow-up;
- Patient and family support; and
- Referrals to community and social support services.

The eligible population will be identified by the MCO and assigned to the participating providers within the eligible population's geographical area. This is an opt-in model and does not require enrollees to change or adjust any of their existing provider relationships.

Injection services provided by licensed nurses to adults ages 21 and older

Does not require prior authorization. Many enrollees are unable or unwilling to take oral psychotropics, or their mental status indicates a need for injectable medication to ensure compliance and stability. Embedded in the cost of many E&M coded visits is the cost of providing injectable medications. Allowing licensed nurses instead of physicians to perform this service delivery results in the most cost efficient and least costly service delivery and helps to ensure compliance. The goals are reducing subsequent office visits and reducing hospitalizations due to lack of compliance.

Mental Health Intensive Outpatient Programs

Requires prior authorization. Mental Health Intensive Outpatient Programs (MH IOPs) provide enrollees treatment via the least restrictive level of care, allowing an alternative to inpatient hospitalization or Assertive Community Treatment and providing a step-down option from inpatient hospitalization for enrollees at high risk for readmission.

Therapeutic Day Center for ages 5-20

Requires prior authorization. The Center for Resilience is a therapeutic day center which provides educational and intensive mental health supports in an innovative partnership with the Tulane University Medical School Department of Child and Adolescent Psychiatry to ensure the emotional well-being and academic readiness of children with behavioral health needs. Children receive instructional, medical, and therapeutic services at the day program site with the goal of building the skills necessary to successfully transition back to the traditional school setting. Center for Resilience provides a caring, non-punitive, therapeutic milieu with positive behavioral supports, trauma-informed approaches, evidence-based mental health practices, small-group classroom instruction, and therapeutic recreation activities. The leadership team is comprised of clinicians, educators, and medical doctors, and the therapeutic milieu is a result of this intentionally interdisciplinary collaboration. The goal of this ILOS is to reduce incidents of crisis hospitalization and residential psychiatric care.

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Louisiana Medicaid Program, Chapter 2, Behavioral Health Services, Section 2.3 Outpatient Services – Individual Placement and Support.

Louisiana Medicaid Program, Chapter 2, Behavioral Health Services, Mobile Crisis Response.

Louisiana Medicaid Program, Chapter 2, Behavioral Health Services, Section 2.3 Outpatient Services – Personal Care Services.

Policy History/Revision Information

Date	Summary of Changes
05/09/2018	Combined previously separate LOCGs into one document Multi-Systemic Therapy (MST). Some previous admission criteria were moved to best practices and the exception section was added.
08/19/2019	Updates to the following per state language for 2019: Admission Common Criteria Assertive Community Treatment Admission Criteria Therapeutic Group Homes number of beds
05/18/2020	State approval
08/24/2020	Revision of CPST and PSR assessment timelines
03/15/2021	State manual and Peer Support additions
02/22/2022	Annual Review and addition of IPS, Crisis Response and PCS.
12/13/2022	Updates to CPST and PSR sections per Louisiana Department of Health, Office of Behavioral Health
05/31/2023	Updates per LDH to the following sections: ABA (removal); ACT; CPST; PSR; Crisis Stabilization; Mobile Crisis; Outpatient Services; Peer Support Services.
07/24/2023	Updates per LDH to ACT services
12/19/2023	Updates per LDH to CPST, Peer Support Services, and Outpatient Services • Approved by state • Previously approved by health plan and UM committee

Date	Summary of Changes

05/01/2024	Updates per LDH to the following services:
	• Crisis Response Services
	  • Mobile Crisis Response
	  • Community Brief Crisis Support
	• Peer Support Services
	• Approved by state
	• Previously approved by health plan and UM committee

TBD	**Annual Review with updates to:** **• CPST** **• Crisis Stabilization for Youth and Adults** **• Functional Family Therapy (FFT)** **• Functional Family Therapy – Child Welfare (FFT-CW)** **• Homebuilders** **• Individual Placement and Support Services** **• MST** **• Outpatient Therapy by Licensed Practitioners** **• Peer Support Services** **• Personal Care Services** **• TGH** **Added services:** **• DBT** • **ILOS**

[iii]

[iiii] Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care.

In order to be considered medically necessary, services must be:

- deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and
- those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the recipient.
- Any such services must be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time.
- Although a service may be deemed medically necessary, it doesn't mean the service will be covered under the Medicaid Program. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary.