



United Behavioral Health

Supplemental Clinical Criteria: Louisiana Medicaid

Document Number: BH803LA012020

Effective Date: XXXX XX, 2020

Table of Contents

[Introduction & Instructions for Use](#)

[Evidence-Based Practice Criteria](#)

[Applied Behavior Analysis \(ABA\)](#)

[Assertive Community Treatment \(ACT\)](#)

[Community Psychiatric Support Treatment \(CPST\)](#)

[Crisis Intervention \(CI\)](#) (~~Please apply LOCUS/CASII/ECSII~~)

[Crisis Stabilization](#) and Assessment (~~Please apply LOCUS/CASII/ECSII~~)

[Functional Family Therapy \(FFT\) and Functional Family Therapy - Child Welfare \(FFT-CW\)](#)

[Homebuilders®](#)

[Inpatient Hospitalization](#) (~~Please apply LOCUS/CASII/ECSII~~)

[Multisystemic Therapy \(MST\)](#)

[Outpatient Services](#) (~~Please apply LOCUS/CASII/ECSII~~)

[Psychiatric Residential Treatment Facility \(PRTF\)](#)

[Psychosocial Rehabilitation \(PSR\)](#) (~~Please apply LOCUS/CASII/ECSII~~)

[Therapeutic Foster Care \(TFC\)](#)

[Therapeutic Group Home](#)

[References](#)

[Revision History](#)

INTRODUCTION & INSTRUCTIONS FOR USE

The following *State or Contract Specific Clinical Criteria*¹ 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*² may apply when making behavioral health medical necessity determinations for members of behavioral health plans managed by Optum®³. These may

¹ **Clinical Criteria (State or Contract Specific): Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.**

² **Clinical Criteria**

(Level of Care Utilization System-LOCUS) Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make medical necessity determinations and placement decisions for adults ages 19 and older.

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. 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.

INSTRUCTIONS FOR USE

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

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

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

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

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

COMMON CRITERIA

Admission Criteria

- The member's current condition cannot be safely, efficiently, and effectively assessed and/or treated in a less intensive level of care.
 - Failure of treatment in a less intensive level of care is **not** a prerequisite for authorizing coverage.
 - The member's condition includes consideration of the acute and chronic symptoms in the member's history and presentation including co-occurring behavioral health or medical conditions, informed by the information collected by the provider following evaluation and treatment planning described in the Common Best Practices.

AND

- The member's condition can be safely, efficiently, and effectively assessed and/or treated in the proposed level of care. Assessment and/or treatment of the member's condition requires the intensity and scope of services provided in the proposed level of care.

AND

- Co-occurring behavioral health and medical conditions can be safely managed in the proposed level of care.

(Child and Adolescent Service Intensity Instrument-CASII)-Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make medical necessity determinations and to provide level of service intensity recommendations for children and adolescents ages 6-18.

(Early Childhood Service Intensity Instrument-ECSII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make medical necessity determinations and to provide level of service intensity recommendations for children ages 0-5.

(ASAM Criteria) Criteria used to make medical necessity determinations for substance-related disorder benefits.

³ Optum is a brand used by United Behavioral Health and its affiliates.

AND

- ~~Services are medical necessary. According to the Louisiana Administrative Code Title 50, Part I, Chapter 11 medically necessary services are defined as those health care services 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".~~
 - ~~The Medicaid director, in consultation with the Medicaid medical director, may consider authorizing services at their discretion on a case-by-case basis.~~

AND

- ~~For all levels of care, services must be for the purpose of diagnostic study or reasonably be expected to improve the patient's condition. The treatment must, at a minimum, be designed to reduce or control the patient's psychiatric symptoms so as to prevent relapse or hospitalization, and improve or maintain the patient's level of functioning.~~
- ~~It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness, although this may be appropriate for some patient. For many other psychiatric patients, particularly those with long-term chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that if treatment were withdrawn the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion is met.~~
- ~~In addition to the above, for outpatient services, some patients may undergo a course of treatment that increases their level of functioning but then reach a point where further significant increase is not expected. Such claims are not automatically considered noncovered because conditions have stabilized, or because treatment is now primarily for the purpose of maintaining a present level of functioning. Rather, coverage depends on whether the criteria discussed above are met; for example, that stability can be maintained without further treatment or with less intensive treatment.~~

Continuing Stay Criteria

- ~~The admission criteria continue to be met and active treatment is being provided. For treatment to be considered "active", service(s) must be as follows:~~
 - ~~Supervised and evaluated by the admitting provider;~~
 - ~~Provided under an individualized treatment plan consistent with Common Clinical Best Practices;~~

- Reasonably expected to improve the member's presenting problems.

AND

- The factors leading to admission have been identified and are integrated into the treatment and discharge plans.

AND

- Clinical best practices are being provided with sufficient intensity to address the member's treatment needs.

AND

- The member's family and other natural resources are engaged to participate in the member's treatment as clinically indicated and feasible.

Discharge Criteria

- The continued stay criteria are no longer met. Examples include:
 - The member's condition no longer requires care.
 - The member's condition has changed to the extent that the condition now meets admission criteria for another level of care.
 - Treatment is primarily for the purpose of providing social, custodial, recreational, or respite care.
 - The member requires medical/surgical treatment.
 - After an initial assessment the member is unwilling or unable to participate in treatment despite motivational support or intervention to engage in treatment, and involuntary treatment or guardianship is not being pursued.

COMMON CLINICAL BEST PRACTICES

Introduction

In assessing whether the criteria set forth in these guidelines is satisfied, staff should consider the clinical information collected from the provider following evaluation and treatment planning described in Common Clinical Best Practices. Staff should update the clinical information through continued consultation with the provider at appropriate intervals as the treatment progresses, including information about new or different symptoms or conditions that may emerge in the course of treatment.

Evaluation & Treatment Planning

- The initial evaluation:
 - Gathers information about the presenting issues from the member's perspective, and includes the member's understanding of the factors that lead to requesting services;
 - Focuses on the member's specific needs;
 - Identifies the member's goals and expectations;
 - Is completed in a timeframe commensurate with the member's needs, or otherwise in accordance with clinical best practices.
- The provider collects information from the member and other sources, and completes an initial evaluation of the following:
 - The member's chief complaint;
 - The history of the presenting illness;
 - The factors leading to the request for service;
 - The member's mental status;
 - The member's current level of functioning;

- Urgent needs, including those related to the risk of harm to self, others, and/or property;
- The member's use of alcohol, tobacco, or drugs;
- Co-occurring behavioral health and physical conditions;
- The member's history of behavioral health services;
- The member's history of trauma;
- The member's medical history and current physical health status;
- The member's developmental history;
- Pertinent current and historical life information;
- The member's strengths;
- Barriers to care;
- The member's instructions for treatment, or appointment of a representative to make decisions about treatment;
- The member's broader recovery, resiliency, and wellbeing goals.
- The provider uses the findings of the evaluation to assign a DSM-ICD diagnosis.
- The provider and, whenever possible, the member use the findings of the initial evaluation and diagnosis to develop a treatment plan. The treatment plan addresses the following:
 - The short and long term goals of treatment;
 - The type, amount, frequency, and duration of treatment;
 - The expected outcome for each problem to be addressed expressed in terms that are measurable, functional, time-framed, and related to the factors leading to admission;
 - How the member's family and other natural resources will participate in treatment when clinically indicated;
 - How treatment will be coordinated with other provider(s), as well as with agencies or programs with which the member is involved.
- As needed, the treatment plan also includes interventions that enhance the member's motivation, promote informed decisions, and support the member's recovery, resiliency, and wellbeing. Examples include psychoeducation, motivational interviewing, recovery and resiliency planning, advance directive planning, and facilitating involvement with self-help and wraparound services.
- The provider informs the member of safe and effective treatment alternatives, as well as the potential risks and benefits of the proposed treatment. The member gives informed consent acknowledging willingness and ability to participate in treatment and abide by safety precautions.
- Treatment focuses on the member's condition including the factors precipitating admission to the point that the member's condition can be safely, efficiently, and effectively treated in a less intensive level of care, or the member no longer requires care.
- The treatment plan and level of care are reassessed when the member's condition improves, worsens, or does not respond to treatment.
 - When the member's condition has improved, the provider determines if the treatment plan should be altered, or if treatment is no longer required.
 - When the member's condition has worsened or not responded to treatment, the provider verifies the diagnosis, alters the treatment plan, or determines if the member's condition should be treated in another level of care.

- In the event that all information is unavailable at the time of the evaluation, there must be enough information to provide a basis for the diagnosis, guide the development of the treatment plan, and support the need for treatment in the proposed level of care.

Discharge Planning

- The provider and, whenever possible, the member develops an initial discharge plan at the time of admission, and estimates the length of treatment.
- The provider and, whenever possible, the member updates the initial discharge plan during the admission, ensuring that:
 - An appropriate discharge plan is in place prior to discharge;
 - The discharge plan is designed to mitigate the risk that the factors precipitating admission will reoccur;
 - The member agrees with the discharge plan.
- For members continuing treatment:
 - The discharge plan includes the following:
 - The discharge date;
 - The post discharge level of care, and the recommended forms and frequency of treatment;
 - The name(s) of the provider(s) who will deliver treatment;
 - The date of the first appointment, including the date of the first medication management visit;
 - The name, dose, and frequency of each medication, with a prescription sufficient to last until the first medication management visit;
 - An appointment for necessary lab tests;
 - Resources to assist the member with overcoming barriers to care, such as lack of transportation or child care;
 - Recommended self-help and community support services;
 - Information about what the member should do in the event of a crisis prior to the first appointment.
- For members not continuing treatment:
 - The discharge plan includes the following:
 - The discharge date;
 - Recommended self-help and community support services;
 - Information about what the member should do in the event of a crisis or to resume services.

The provider explains the risk of discontinuing treatment when the member refuses treatment or repeatedly does not adhere with the treatment plan.

EVIDENCE-BASED PRACTICE CRITERIA

In addition to the applicable Clinical Criteria, for all services, treatments and levels of care, services are delivered according to evidence-based practices consistent with the applicable definition of Medical Necessity and the following⁴:

- **Services are:**
 - **Provided under an individualized plan of treatment or diagnostic plan developed in conjunction with providers of appropriate disciplines on the basis of a thorough evaluation of the member's strengths and disabilities;**
 - **Supervised and evaluated by the most appropriate physician or provider;**
 - **For the purpose of diagnosis or services are reasonably expected to improve the member's condition:**
 - **It is not necessary that a course of therapy have as its goal restoration of the member to the level of functioning exhibited prior to the onset of the illness, although this may be appropriate for some members. For many other members, particularly those with long-term, chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement.**
 - **"Improvement" in this context is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that if treatment services were withdrawn the member's condition would deteriorate, relapse further, or require hospitalization, this criterion is met.**
- **The individualized written plan includes the type, amount frequency, and duration of the services to be furnished and indicate the diagnoses and anticipated goals.**
- **For continued service, the member continues to show improvement in accordance with his/her individualized treatment plan, and the frequency of services is within accepted norms of medical practice.**
- **Discharge is indicated when stability can be maintained without further treatment or with less intensive treatment.**
 - **Discharge planning includes linkages with community resources, supports, and providers in order to promote a member's return to a higher level of functioning in the least restrictive environment.**

A discharge plan and a summary with recommendations for appropriate services concerning follow-up or aftercare have been developed as well as a summary of the member's condition upon discharge.

APPLIED BEHAVIOR ANALYSIS (ABA)

APPLIED BEHAVIOR ANALYSIS (ABA) is the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including direct observation, measurement, and functional analysis of the relations between environment and behavior. ABA therapies teach skills through the use of

⁴ **The Evidence-Based Practice Criteria ensures that as required by federal & state regulations and contractual requirements, Optum's Clinical Criteria is based on sound clinical evidence for coverage determinations and is used to inform discussions about evidence-based practices, treatment planning and discharge planning with providers. The Evidence-Based Practice Criteria is applicable across all service levels and considers Medical Necessity as well as the appropriateness of services for the member's diagnosis, treatment plan and needs throughout the duration of treatment. These references to "evidence-based" are not meant to discuss individual treatment modalities, such as Rehabilitation Services category (MST, FFT, FFT-CW, HB, ACT) or services such as PCIT, CPP; but rather the evidence-based common treatment elements when delivering all behavioral health services.**

behavioral observation and reinforcement or prompting to teach each step of targeted behavior. ABA therapies are based on reliable evidence and are not experimental.

Admission Criteria

- ~~See Common Admission Criteria~~
AND
- The recipient is under the age of 21.
AND
- The recipient has been diagnosed with a condition for which ABA therapy services are recognized as therapeutically appropriate, including (but not limited to) autism spectrum disorder, by a qualified health care professional.
AND
- The recipient exhibits the presence of excesses and/or deficits of behaviors that significantly interfere with home or community activities (e.g., aggression, self-injury, elopement, etc.).
AND
- The recipient must have the following documents submitted as a part of the prior authorization process:
 - A completed comprehensive diagnostic evaluation (CDE) indicating medical necessity and which has been performed by a qualified health care professional (QHCP).
 - The CDE must at a minimum include:
 - A thorough clinical history with the informed parent/caregiver, inclusive of developmental and psychosocial history;
 - Direct observation of the recipient, including but not limited to, assessment of current functioning in the areas of social and communicative behaviors and play or peer interactive behaviors;
 - A review of available records;
 - A valid *Diagnostic and Statistical Manual of Mental Disorders*, (DSM) V (or current edition) diagnosis;
 - Justification/rational for referral/non-referral for an ABA functional assessment and possible ABA services; and
 - Recommendations for an additional treatment, care or services, specialty medical or behavioral referrals, specialty consultations, and/or additional recommended standardized measures, labs or other diagnostic evaluations considered clinically appropriate and/or medically necessary.
 - When the results of the screening are borderline, or if there is any lack of clarity about the primary diagnosis, comorbid conditions or the medical necessity of services requested, the following categories of assessment should be included as components of the CDE and must be specific to the recipient's age and cognitive abilities:
 - Autism specific assessments;
 - Assessment of general psychopathology;
 - Cognitive assessment; and
 - Assessment of adaptive behavior.
 - ~~A CDE completed more than 18 months prior to the date of service authorization request may require an update, progress report, or re-evaluation by a QHCP.~~
 - A QHCP is defined as any of the following:
 - Pediatric Neurologist;
 - Developmental Pediatrician;
 - Psychologist (**including a Medical Psychologist**), Psychiatrist (**particularly Pediatric and Child Psychiatrist**); or
 - Licensed individual that has been approved by the Medicaid medical director.
 - A prescription for ABA therapy services ordered by a QHCP;
 - A behavior treatment plan that;
 - Is person-centered and based upon individualized goals;
 - Delineates the frequency of baseline behaviors and the treatment development plan to address the behaviors;
 - Identifies long-term, intermediate, and short-term goals and objectives that are behaviorally defined;
 - Identifies the criteria that will be used to measure achievement of behavior objectives;

- Clearly identifies the schedule of services planned and the individual providers responsible for delivering the services;
- Includes care coordination, involving the parents or caregiver(s), school, state disability programs, and others as applicable;
- Includes parent/caregiver training, support, and participation; Has objectives that are specific, measurable, based upon clinical observations of the outcome measurement assessment and tailored to the recipient; and
- Ensures that interventions are consistent with ABA techniques.
- Is submitted on the template provided by Louisiana¹ or on the provider's own form. If the provider chooses to use their own form, the provider must address all of the relevant information specified on the template including;

The recipient's:

- Full name;
- Medicaid ID number;
- Date of birth;
- Address;
- Home and cell phone numbers.

The provider's:

- Name;
- Medicaid ID number;
- Phone number;
- Address;
- Contact person's email address.
- The recipient's diagnosis.

The number of hours per week requested for:

- Registered Line Technician;
- Supervision conducted by the Board Certified Behavior Analyst – Doctoral (BCBA/-D);
- Direct services provided by a BCBA/-D, including caregiver training;
- Total number of requested hours for all services.
 - The anticipated total hours of service (therapy and supervision) each day during the school year and summer as applicable.
 - The specific criteria used to determine the need for ABA therapy at the hours requested.
 - The predominant location where services will occur.
 - If services will occur in more than one location, those additional locations should also be listed.
 - A narrative description of the baseline level of all behaviors assessed for which a goal is developed.
 - Idiosyncratic, proprietary assessment instrument results may not be used to describe baseline performance.
 - If the document is a treatment plan renewal, a description of the present level of performance for skills under treatment and any goals mastered during the previous authorization period.
 - A goal for each behavior/skill identified for treatment not including behavior reduction goals. Each goal should have a performance standard and a criterion for mastery.
 - Idiosyncratic, proprietary nomenclature may not be used to specify treatment goals.
 - If the provider is going to intervene on problem behaviors the provider must:
 - Conduct a functional assessment or a functional analysis and develop a function based treatment plan.
 - Include the results of the functional assessment and a hypothesis statement or describe the results of a functional analysis.
 - Include the behavior topography of the problem behavior and state the frequency/duration/latency/intensity of all the problem behaviors for which a goal is developed.
 - Include behavior improvement goals with a performance standard and a criteria for mastery.

- Include the behavior intervention plan that addresses the function of the problem behavior that includes strengthening a functional replacement behavior.
 - A grid sheet with intervention tactics may be used only if it is tied to a narrative description/date analysis of the results of the functional assessment/analysis.
 - Caregiver training with a performance standard and criteria for mastery.
 - The dated signatures of the:
 - Parent/guardian:
 - Provider Representative
 - Physician
 - An individualized education program (IEP) (if applicable);
 - If the IEP is not included the provider should explain why they were unable to furnish it;
 - If the services are to be delivered in a school setting, the service will not be approved until an IEP is provided.
 - A waiver plan profile table and the schedule from the certified plan of care (if the recipient is in a waiver and services are being requested that will occur at the same time as waiver services).
- AND
- ABA services are to be delivered in accordance with the recipient's behavior treatment plan.
- AND
- ABA services will be provided by, or under the supervision of, a behavior analyst who is currently licensed by the Louisiana Behavior Analyst Board, or a licensed psychologist or licensed medical psychologist.
- AND
- ABA services are to be provided in a natural setting (e.g., home and community-based settings, including clinics and school).
- AND
- The member is not in imminent or current risk of harm to self, others, and/or property.

~~Continuing Stay Criteria~~

- ~~See Common Continuing Stay Criteria~~

~~Discharge Criteria~~

- ~~See Common Discharge Criteria~~

~~Clinical Best Practices~~

- ~~See Common Clinical Best Practices~~

Service Delivery

- Treatment plan services should include care coordination involving the recipient's parent/caregiver.
- Services should include parent/caregiver training, support and participation.

Limitations and Exclusions

- A prior authorization period shall not exceed 180 days.
- The following services do not meet medical necessity criteria, and do not qualify as Medicaid covered ABA-based therapy services:
 - Therapy services rendered when measurable functional improvement or continued clinical benefit is not expected, and therapy is not necessary or expected for maintenance of function or to prevent deterioration;
 - Service that is primarily educational in nature;
 - Services delivered outside of the school setting that duplicate services under an individualized family service plan (IFSP) or an IEP, as required under the federal Individuals with Disabilities Education act (IDEA);
 - Treatment whose purpose is vocationally or recreationally based;
 - Custodial care that:
 - Is provided primarily to assist in activities of daily living (ADLs)
 - Is provided primarily for maintaining the recipient's or anyone else's safety; or

- Could be provided by persons without professional skills or training; and
- Services, supplies or procedures performed in a non-conventional setting including, but not limited to:
 - Resorts;
 - Spas;
 - Therapeutic programs; or
 - Camps.

ASSERTIVE COMMUNITY TREATMENT (ACT)

ASSERTIVE COMMUNITY TREATMENT (ACT)

Assertive Community Treatment (a.k.a. Program of Assertive Community Treatment, PACT, ACT) is an intensive community-based program that uses a multi-disciplinary team of behavioral health professionals and trained peers to provide or coordinate treatment, rehabilitation, and community support services for members who are recovering from severe mental health conditions.

Assertive Community Treatment services are provided as interventions that address the functional problems of members who have the most complex and/or pervasive conditions associated with a major mental illness or co-occurring ~~addictions~~ substance use disorder. These interventions are strength-based and focused on promoting symptom stability, increasing the member's ability to cope and relate to others and enhancing the highest level of functioning in the community.

Assertive Community Treatment services are therapeutic interventions that address the functional problems of individuals who have the most complex and/or pervasive conditions associated with a major mental illness or co-occurring ~~addictions~~ substance use disorder. These interventions are strength-based and focused on promoting symptom stability, increasing the member's ability to cope and relate to others and enhancing the highest level of functioning in the community.

Interventions may address adaptive and recovery skill areas, such as supportive or other types of housing, school and training opportunities, daily activities, health and safety, medication support, harm reduction, money management and entitlements and service planning and coordination.

Assertive Community Treatment services may be mobile or delivered within an outpatient treatment setting, and are available 24 hours a day, 7 days a week. At least 90 percent of services are delivered as community-based outreach services. These services provide mobilized crisis intervention in various environments, such as the recipient's home, schools, jails, homeless shelters, streets and other locations. These services may arrange or assist consumers to make a housing application, meet their housing obligations and gain the skills necessary to maintain their home.

Assertive Community Treatment services vary in intensity, frequency, and duration in order to support the member's ability to utilize behavioral health and medical services, manage functional difficulties, or otherwise realize recovery and resiliency goals.

Admission Criteria

- ~~See Common Admission Criteria~~
AND

- The member is diagnosed with one or more of the following Serious and Persistent Mental Illness (SPMI) diagnoses listed in the DSM-5 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
 - Developmental disability

AND

- The member meets one or more of the following:
 - Two or more acute psychiatric hospitalization and/or four or more emergency room visits in the last six months.
 - Persistent and severe symptoms of a psychiatric disability that interferes with the ability to function in daily life.

- Two or more interactions with law enforcement in the past year for emergency services due to mental illness or substance use (this includes involuntary commitment, ACT/Forensic Assertive Community Treatment (FACT)).
- 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 (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).
- Recommendations by probation and parole, or a judge with a FACT screening interview, indicating services are necessary to prevent probation/parole violation (FACT).

AND

- The member meets 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 meets 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 2 years.
 - Suicide attempt in the last 2 years.
 - History of violence due to untreated mental illness/substance use within the last 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 2 years.
 - History of significant psychotic symptomatology, such as command hallucinations to harm others.
 - Minimum LOCUS score of 3 at admission.

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

Continuing Stay Criteria

- ~~See Common 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.

- For members participating in FACT, the assessment will include items related to court orders, identified within 30 days of admission and updated every 90 days or as new court orders are received.
- The LOCUS and psychiatric evaluation will be updated at least every six months or as needed based on the needs of each member, with an additional LOCUS score being completed prior to discharge.
- A service treatment plan, responsive to the member's preferences and choices must be developed and in place at the time services are rendered. The service 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. The plan must contain the signature of the psychiatrist, the team leader involved in the treatment and the member (or documented refusal).
- 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.
- The treatment plan is reviewed and updated every six months. A tracking system is expected of each ACT team for services and time rendered for or on behalf of any member.

The plan must consist of the following:

- The member's specific mental illness diagnosis.
- 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.
- 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.
- A crisis/relapse prevention plan, including and advance directive.
- An integrated substance use and mental health service plan for individuals with co-occurring disorder (COD).
- Any other items that are relevant for any specialized interventions, including linkages with the forensic system for consumers involved in the judicial system.
- ACT staff must be providing a minimum of 6 face to face encounters with the member monthly and must document clinically appropriate reasons if this minimum number of encounters cannot be made monthly. Efforts shall be made to ensure services are provided throughout the month. At least 90 percent of services are to be delivered as community-based outreach services. The LOCUS, psychiatric evaluation and treatment plan must be updated every 6 months or as needed based on the needs of each member with an additional LOCUS score being completed prior to discharge.

Clinical Best Practices

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. Process measures should be obtained through utilization of the EBP Fidelity Scale and General Organizational Index as found within the SAMHSA ACT Toolkit. Outcome measures

such as homelessness, hospitalizations (psychiatric/medical), emergency department presentations (psychiatric/medical), incarcerations and/or arrests/detainments, substance use treatment (residential/inpatient/outpatient), utilizations of primary care physician (PCP), employment and educational status should be collected in addition to the EBP fidelity measures.

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.

COMMUNITY PSYCHIATRIC SUPPORT TREATMENT (CPST)

COMMUNITY PSYCHIATRIC SUPPORT TREATMENT (CPST) is a comprehensive service which focuses on reducing the disability resulting from mental illness, restoring functional skills of daily living, building natural supports and solution-oriented interventions intended to achieve goals or objectives as set forth in the individualized treatment plan. CPST is a face-to-faceⁱⁱ intervention with the individual present; however, family or other collaterals also may be involved. ~~A minimum of 51 percent of CPST~~ Most contacts must occur in community locations where the person lives, works, attends school and/or socializes.

CPST may include the following components:

- Assist the member and family members or other collaterals to identify strategies or treatment options associated with the member's mental illness, with the goal of minimizing the negative effects of mental illness symptoms or emotional disturbances or associated environmental stressors which interfere with the member's daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships, and community integration.
- Individual supportive counseling, solution focused interventions, emotional and behavioral management, and problem behavior analysis with the member, with the goal of assisting the member with developing and implementing social, interpersonal, self-care, daily living, and independent living skills to restore stability, to support functional gains and adapt to community living.
- Participation in, and utilization of, strengths-based planning and treatments, which include assisting the member and family members or other collaterals to identify strengths and needs, resources, and natural supports and developing goals and objectives to use personal strengths, resources, and natural supports to address functional deficits associated with the member's mental illness.
- Assist the member with effectively responding to or avoiding identified precursors or triggers that would risk the member remaining in a natural community location, including assisting the member and family members or other collaterals to identify a potential psychiatric or personal crisis, develop a crisis management plan, and/or as appropriate, to seek other supports to restore stability and functioning.
- Restoration, rehabilitation and support to develop skills to locate, rent and keep a home, landlord/tenant negotiations, selecting a roommate and renter's rights and responsibilities.
- Assisting the individual to develop daily living skills specific to managing their own home, including managing their money, medications and using community resources and other self-care requirements.

Admission Criteria

- ~~See Common Admission Criteria~~
- Services must be recommended by a licensed mental health professional (LMHP) or physician, or under the direction of a licensed practitioner.
AND

- The member meets ~~1915(i)~~ criteria for individuals 21 years and over.
AND
- Members aged 19 and older must be assessed using the Level of Care Utilization System (LOCUS).
OR
- Members aged 6 through 18 must be assessed using the Child Adolescent Level of Care Utilization System (CALOCUS). (CALOCUS is not required for members under the age of 6).
AND
- The member meets medical necessity criteria for rehabilitation services for children under the age of 21.
AND
- Services provided to children and youth must include communication and coordination with the family and/or legal guardian.
 - Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals.
 - All coordination must be documented in the child/youth's record.
- Providers must submit CALOCUS/LOCUS ratings on a form that includes the rating in each dimension, the criteria to support the rating, independent criteria, the composite score, the level of care, a section to document notes, a signature line with credentials, and a rating date.
- **Additional Adult Criteria**
 - **Members must meet the Substance Abuse and Mental Health Services Administration (SAMHSA) definition of, serious mental illness (SMI). In addition to having a diagnosable mental disorder, the condition must substantially interfere with, or limit, one or more major life activities, such as:**
 - **Basic daily living (for example, eating or dressing);**
 - **Instrumental living (for example, taking prescribed medications or getting around the community); and**
 - **Participating in a family, school, or workplace.**
 - **A member must have a rating of three or greater on the functional status domain on the level of care utilization system (LOCUS).**
 - **Members receiving CPST and/or PSR must have at least a level of care of three on the LOCUS.**
 - **An adult with longstanding deficits who does not experience any acute changes in their status and has previously met the criteria stated above regarding LOCUS scores, but who now meets a level of care of two or lower on the LOCUS, and needs subsequent medically necessary services for stabilization and maintenance at a lower intensity, may continue to receive CPST services and/or PSR, if deemed medically necessary.**

Continuing Stay Criteria

- A CALOCUS/LOCUS rating must be completed and submitted for all members every 180 days.

Discharge Criteria

- A CALOCUS/LOCUS rating be completed and submitted at discharge for all members. In the event a member is not available to conduct a final rating upon discharge, the provider should make a note in the member's record. For the discharge rating, a comprehensive assessment is not required; **the rating should be part of the member's discharge summary.**

• See Common Discharge Criteria

Service Delivery

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

CRISIS INTERVENTION (CI)

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, via 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 and services.

Crisis Intervention includes the following components:

- A preliminary assessment of risk, mental status, and medical stability; and the need for further evaluation or other mental health services. 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, treatment and/or referral to other alternative mental health services at an appropriate level.
- Short-term Crisis Intervention includes crisis resolution and de-briefing with the member and the treatment provider.
- Follow-up with the member, and when appropriate, with the member's caretaker and/or family members.
- Consultation with a physician or other qualified providers to assist with the member's specific crisis.

Admission Criteria

- ~~See Common Admission Criteria~~
- AND
- Services must be recommended by a licensed mental health professional (LMHP) or physician, or under the direction of a licensed practitioner.
- AND
- ~~The member meets 1915(i) criteria for members 21 years and over. Individuals, 21 years of age and older, who meet Medicaid eligibility.~~
- OR
- The member meets medical necessity criteria for rehabilitation services for members under the age of 21.
- OR
- The member has self-identified that he/she is experiencing an acute escalation of symptoms resulting in a level of distress that cannot be managed in the member's current situation.
- OR
- The member's family members/collaterals who have knowledge of the crisis situation and the member's typical level of functioning, present the member in need of crisis intervention.

~~Continuing Stay Criteria~~

- ~~See Common Continuing Stay Criteria~~

~~Discharge Criteria~~

- ~~See Common Discharge Criteria~~

~~Clinical Best Practices~~

- ~~See Common Clinical Best Practices~~

Service Delivery

- **CI – Emergent is allowed without the requirement of a prior authorization in order to address the emergent issues in a timely manner. Additional units may be approved with prior authorization.**
- **CI – Ongoing is authorized until the current crisis is resolved. The individual's treatment record must reflect resolution of the crisis, which marks the end of the current episode.**
- **The time spent by the LMHP during face-to-face time with the member is billed separately. This would include the assessment of risk; mental status and medical stability must be completed by the LMHP, choosing the code that best describes the care provided.**
- **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 unlicensed 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 unlicensed 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

CRISIS STABILIZATION Children and Adolescents

Crisis stabilization is intended to provide short-term and intensive supportive resources for 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.**

Crisis Stabilization includes 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.
- Out of home short-term or extended intervention for the identified member based on initial and ongoing assessment of needs including crisis resolution and debriefing.
- Follow up with the member and with the member's caretaker and/or family members.
- Consultation with a physician or with other qualified providers to assist with the member's specific crisis.

Admission Criteria

- ~~See Common Admission Criteria~~
- **AND**
- Services must be recommended by a licensed mental health professional (LMHP) or physician, or under the direction of a licensed practitioner.

AND

- ~~The member is eligible, through a Child and Adolescent Needs and Strengths (CANS) comprehensive screening, for enrollment in the Coordinated System of Care (CSoC) program (Home and Community-Based Services (HCBS), CSoC Severe Emotional Disturbance (SED) Waiver eligible or CSoC Length of Need (LON) under 1915 (b)(3)).~~

~~AND~~

- Services provided to children and youth 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 occurs, as needed, to achieve the treatment goals and all coordination is documented in the member's medical record.

Continuing Stay Criteria

- ~~See Common Continuing Stay Criteria~~

Discharge Criteria

- ~~See Common Discharge Criteria~~

Clinical Best Practices

- ~~See Common Clinical Best Practices~~

Exclusions

- Crisis stabilization is not provided simultaneously with short-term respite care and does not duplicate any other Medicaid State Plan service or service otherwise available to the recipient at no cost.
- **Services rendered in an institute for mental disease.**

FUNCTIONAL FAMILY THERAPY (FFT) AND FUNCTIONAL FAMILY THERAPY – CHILD WELFARE (FFT-CW)

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 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 FFTCW 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 following is met:

Admission Criteria

- ~~See Common 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.
AND
- ~~The member's interagency service planning team recommends that he/she participate in FFT.~~

Continuing Stay Criteria

- The member receives an average of 12 to 30 one-to-two hour sessions in the home or community depending the member's needs over the course of 3-5 months.

~~See Common Continuing Stay Criteria~~

Discharge Criteria

- The member and family demonstrate their ability to utilize resources within the community and demonstrate integration prior to discharge.
- ~~See Common Discharge Criteria~~

Clinical Best Practices

- ~~See Common Clinical Best Practices~~

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 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.

Admission Criteria

~~See Common 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
 - Incurability
 - 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.
- ~~See Common Continuing Stay Criteria~~

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.
- ~~See Common Discharge Criteria~~

Exclusions

- **Homebuilders 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 recipient receiving Homebuilders services.**

Please apply LOCUS/CASII/ECSII criteria

INPATIENT HOSPITALIZATION Children and Adolescents

A structured hospital-based program which provides 24-hour/7-day nursing care, medical monitoring, and physician availability; assessment and diagnostic services, active behavioral health treatment, and specialty medical consultation with an immediacy needed to avoid serious jeopardy to the health of the member or others.

The course of treatment in an inpatient setting is focused on addressing the factors that precipitated admission (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the member's condition can be safely, efficiently and effectively treated in a less intensive level of care.

Admission Criteria

- See Common Admission Criteria
AND
- The precipitating factors leading to admission, and/or the member's history of response to treatment suggest that there is imminent or current risk of harm to self, others, and/or property which cannot be safely, efficiently, and effectively managed in a less intensive level of care. Examples include the following:
 - A life-threatening suicide attempt;
 - Self-mutilation, injury or violence toward others or property;
 - Threat of serious harm to self or others;
 - Command hallucinations directing harm to self or others.OR
- The precipitating factors leading to admission suggest that the member's condition cannot be safely, efficiently, and effectively treated in a less intensive setting due to a physical complication. Example include:
 - A physical cause for the member's signs and symptoms cannot be ruled out in a less intensive setting.
 - A severe medication side effect requires the level of monitoring and intervention available in an inpatient setting.OR
- The precipitating factors leading to admission cannot be safely, efficiently, and effectively assessed and/or treated in a less intensive setting due to acute changes in the member's signs and symptoms, and/or psychosocial and environmental factors. Examples include:
 - Acute impairment of behavior or cognition that interferes with activities of daily living to the extent that the welfare of the member or others is endangered.
 - Psychosocial and environmental problems that threaten the member's safety or undermines engagement in a less intensive level of care.OR
- The precipitating factors which led to admission to Crisis Stabilization & Assessment or 23-Hour Observation cannot be addressed, and the member must be admitted to inpatient.

Continuing Stay Criteria

- See Common Continuing Stay Criteria
AND
- Treatment is not primarily for the purpose of providing custodial care. Services are custodial when they are any of the following:
 - Non-health related services, such as assistance with Activities of Daily Living (examples include feeding, dressing, bathing, transferring and ambulating);
 - Health-related services provided for the primary purpose of meeting the personal needs of the member or maintaining a level of function (even if the specific services are considered to be

skilled services), as opposed to improving that function to an extent that might allow for a more independent existence;

- ~~Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.~~

Discharge Criteria

- ~~See Common Discharge Criteria~~

Clinical Best Practices

~~See Common Clinical Best Practices~~

MULTISYSTEMIC THERAPY (MST)

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

~~See Common 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.
AND
- There is ongoing multiple system involvement due to high risk behaviors and/or risk of failure in mainstream school settings due to behavioral problems.
AND
- Less intensive treatment has been ineffective or is inappropriate.
OR
- The member's treatment planning team or CFT recommends that he/she participate in MST.
AND
- .

Continuing Stay Criteria

~~See Common 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

~~See Common 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

~~Clinical Best Practices~~

~~• See Common Clinical Best Practices~~

- 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.

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 SERVICES

OUTPATIENT 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

~~• See Common Admission Criteria~~

~~AND~~

- **Members are adults or children that meet medical necessity criteria.** ~~is not in imminent or current risk of harm to self, others, and/or property.~~
~~AND~~
- ~~Acute changes in the member's signs and symptoms, and/or psychosocial and environmental factors (i.e., the factors leading to admission) have occurred, and the member's current condition can be safely, efficiently, and effectively assessed and/or treated in this setting.~~

Continuing Stay Criteria

- See Common Continuing Stay Criteria

Discharge Criteria

- See Common Discharge Criteria

Clinical Best Practices

- See Common Clinical Best Practices

Service Delivery

- **Allowed modes of service are individual, family, group, on-site, off-site, and tele-video.**
- **Licensed Practitioner Outpatient Therapy includes:**
 - **Individual outpatient psychotherapy;**
 - **Family outpatient psychotherapy;**
 - **Group outpatient psychotherapy;**
 - **Mental health assessment;**
 - **Evaluation;**
 - **Testing;**
 - **Medication management;**
 - **Psychiatric evaluation;**
 - **Medication administration; and**
 - **Individual therapy with medical evaluation and management and case consultation.**

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF)

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF) A sub-acute facility-based program which delivers 24-hour/7-day assessment and diagnostic services, and active psychiatric treatment under the direction of a physician to members under the age of 21 who have functional impairments resulting from a behavioral health condition that have not responded to treatment in other community settings.

The course of treatment in a PRTF is focused on addressing the factors that precipitated admission (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the member's condition can be safely, efficiently and effectively treated in a less intensive level of care and/or restore the member to his/her best possible functioning level in the community.

Psychiatric residential treatment facilities (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. The PRTF ensures that the resident 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 recipient's situation. Each PRTF program should incorporate appropriate research-based programming for both treatment planning and service delivery. The PRTF team includes, at a minimum, a board-eligible or board-certified psychiatrist; a clinical psychologist and a physician licensed to practice medicine or osteopathy; and a physician licensed to practice medicine or osteopathy, with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been licensed by the State psychological association. A team should include at least one of the following: a licensed clinical social worker (LCSW); a RN with specialized training or one year's experience in treating mentally ill individuals; an occupational therapist who is licensed, if required by the State, and who has specialized training or one year of experience in treating mentally ill individuals; and/or a psychologist who is licensed by the State psychological association.

Admission Criteria

~~See Common Admission Criteria~~

- The member's current signs and symptoms meet criteria for a psychiatric DSM diagnosis.
AND
- Ambulatory care resources available in the community do not meet the member's treatment needs.
AND
- ~~There is a substantial risk of harm to self or others, or the member is unable to care for his or her own physical health and safety so as to create a danger to his or her life.~~
AND
- The factors that precipitated admission indicate that the member requires assistance with restoring skills and abilities essential to functioning. Examples of functional impairment include:
 - Severely impaired social, familial, academic or occupational functioning which may include excessive use of alcohol or drugs.
 - Severely maladaptive or destructive behaviors in school, home, or placement which may include excessive use of alcohol or drugs.
 - Extreme impulsivity demonstrating limited ability to delay gratification.
 - Sexual acting-out that is harmful to self or others, and/or is age inappropriate.
 - A history of running away which puts the member or others at risk.AND
- Proper treatment of the member's behavioral health condition requires PRTF services under the direction of a physician.
AND
- PRTF services can be reasonably expected to improve the member's condition or prevent further regression so that services will no longer be needed.

Continuing Stay Criteria

~~See Common Continuing Stay Criteria~~

- The admission criteria continue to be met and active treatment is being provided.
AND
- Clinical best practices are being provided with sufficient intensity to address the member's treatment needs.
AND
- The services are provided within the context of the family, not as an isolated unit and be appropriate for the member's:
 - Age;
 - Development;
 - Education; and
 - Culture

Discharge Criteria

~~See Common Discharge Criteria~~

- The member has reached age 22.
OR
- PRTF goals have been met.
OR
- PRTF goals have not been met; the member is transferred to another inpatient behavioral health or medical service.
OR
- PRTF goals have not been met; the member or member's guardian chooses to discontinue services.
OR
- The member is placed in a correctional facility, or removed from treatment and placed for longer than 72 hours while awaiting a court hearing.
OR
- The member has run away from the facility and is gone for 7 consecutive calendar days with the facility having no knowledge of when the member may return.

OR

- The member has died.

Clinical Best Practices

- See Common Clinical Best Practices

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.**

Limitations and Exclusions

- **The PRTF is compliant with seclusion and restraint requirements.**
- **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).**

PSYCHOSOCIAL REHABILITATION (PSR)

PSYCHOSOCIAL REHABILITATION (PSR) Adults, Children & Adolescents

Psychosocial rehabilitation 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. A minimum of 51% of a PSR's contacts must occur in community locations where the person lives, works, attends school and/or socializes.

Psychosocial Rehabilitation is focused on addressing the factors that precipitated the need for this service (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the member's condition can be safely, efficiently and effectively treated without the support of Psychosocial Rehabilitation.

Psychosocial Rehabilitation is provided in conjunction with traditional pharmacologic and psychosocial treatments.

Psychosocial Rehabilitation services vary in intensity, frequency, and duration in order to support the member's ability to manage functional difficulties, and realize recovery and resiliency goals.

Psychosocial Rehabilitation components include:

- **Restoration, rehabilitation and support to develop social and interpersonal skills to increase community tenure, enhance personal relationships, establish support networks, increase community awareness, develop coping strategies and effective functioning in the individual's social environment, including home, work and school;**
 - **Restoration, rehabilitation and support to develop 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; and**
 - **NOTE: PSR services are psycho-educational services associated with assisting individuals with skill-building, restoration and rehabilitation, and should not be confused with counseling, psychotherapy or other clinical treatment, which may only be provided by a licensed professional.**
 - **Implementing learned skills so the member can remain in a natural community location and achieve developmentally appropriate functioning, and assisting the individual with effectively responding to or avoiding identified precursors or triggers that result in functional impairment.**

Admission Criteria

- **Members receiving PSR, ages 6 through 18 years of age, must be assessed using the CALOCUS.**
- **Members receiving PSR, ages 19 and older, must be assessed using the LOCUS.**
- **Additional Adult Criteria**
 - **Members must meet the Substance Abuse and Mental Health Services Administration (SAMHSA) definition of, serious mental illness (SMI). In addition to having a diagnosable mental disorder, the condition must substantially interfere with, or limit, one or more major life activities, such as:**
 - **Basic daily living (for example, eating or dressing);**
 - **Instrumental living (for example, taking prescribed medications or getting around the community); and**
 - **Participating in a family, school, or workplace.**
 - **A member must have a rating of three or greater on the functional status domain on the level of care utilization system (LOCUS).**
 - **Members receiving CPST and/or PSR must have at least a level of care of three on the LOCUS.**

- **An adult with longstanding deficits who does not experience any acute changes in their status and has previously met the criteria stated above regarding LOCUS scores, but who now meets a level of care of two or lower on the LOCUS, and needs subsequent medically necessary services for stabilization and maintenance at a lower intensity, may continue to receive CPST services and/or PSR, if deemed medically necessary.**
- ~~See Common Admission Criteria~~
~~AND~~
- ~~The member is not in imminent or current risk of harm to self or others and/or property.~~
~~AND~~
- ~~The factors that precipitated admission (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) indicate that the member requires assistance with accessing treatment and/or community resources. Examples include:
The member has difficulty gaining and utilizing necessary functional skills such as those related to:~~
 - ~~Education or work;~~
 - ~~Finances;~~
 - ~~Housing;~~
 - ~~Health/medical;~~
 - ~~Social needs;~~
 - ~~Basic living skills;~~
 - ~~Legal needs.~~~~AND~~
- ~~Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur, as needed, to achieve the treatment goals.~~

Continuing Stay Criteria

- **A CALOCUS/LOCUS rating must be completed and submitted for all members every 180 days.**

Discharge Criteria

- **A CALOCUS/LOCUS rating be completed and submitted for all members at discharge. In the event a member is not available to conduct a final rating upon discharge, the provider should make a note in the member's record. For the discharge rating, a comprehensive assessment is not required. The rating should be part of the member's discharge summary.**

Continuing Stay Criteria

- ~~See Common Continuing Stay Criteria~~

Discharge Criteria

- ~~See Common Discharge Criteria~~

Clinical Best Practices

- ~~See Common Clinical Best Practices~~

Service Delivery

- **Allowed modes of service are individual, family, group, on-site, and off-site.**

THERAPEUTIC FOSTER CARE (TFC)

THERAPEUTIC FOSTER CARE (TFC) Therapeutic Foster Care provides a structured home environment in which specifically trained foster parents teach social, behavioral, and emotional skills to children and adolescents who are at risk of placement, or who have complex and significant behavioral health problems which cannot be managed at home. The course of treatment is focused on

addressing the member's condition to the point that the member's condition can be safely, efficiently and effectively treated in a less intensive level of care or no longer requires treatment. The member's condition includes consideration of the acute and chronic symptoms in the member's history and presentation, including co-occurring behavioral health or medical conditions, informed by information collected by the provider following evaluation and treatment planning as described in Common Clinical Best Practices.

Placements in a therapeutic foster home are usually limited to two youths per family. Whenever appropriate, Therapeutic Foster Care supports family permanence by also training the parent(s)/guardian(s) to manage the member's needs and behavior, and by providing case management.

Therapeutic Foster Care varies in intensity and duration in order to support the member's ability to manage functional difficulties and enhance the member's resiliency.

Admission Criteria

See Common Admission Criteria

- The member is not in imminent or current risk of harm to self, others, and/or property.
AND
- The factors that precipitated access to this service (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) indicate that the member cannot be suitably cared for in the member's home. Examples include:
 - The member is at risk for placement.
 - The member has complex and significant behavioral health problems that cannot be managed by the member's family or caregiver.

Continuing Stay Criteria

- See Common Continuing Stay Criteria

Discharge Criteria

- See Common Discharge Criteria

Clinical Best Practices

- See Common Clinical Best Practices

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 under the supervision and program oversight of a psychiatrist or psychologist. The setting is geographically situated to allow ongoing participation of the child's family. The child or adolescent attends a school in the community (e.g., a school integrated with children not from the group home and not on the group home's campus).

The treatment should be targeted to support the development of adaptive and functional behaviors that will enable the child or adolescent to remain successfully in his/her home and community and to regularly attend and participate in work, school or training. The member remains involved in community-based activities and may attend educational, vocational or other treatments in the community.

The course of treatment is focused on addressing the factors that precipitated admission the need for TGH services (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the member's condition can be safely, efficiently and effectively treated in a less intensive level of care. The TGH coordinates with the child's or adolescent's community resources, including schools, with the goal of transitioning the youth out of the program to a less restrictive care setting.

Admission Criteria

See Common Admission Criteria

- The member is eligible for benefitsⁱⁱⁱ.
AND
- The member's current condition cannot be safely, efficiently and effectively assessed and/or treated in a less intensive setting due to changes in the member's signs and symptoms, level of functioning, and/or psychosocial and environmental factors (i.e., the "why now" factor leading the member to the TGH services).
 - Failure of treatment in a lower level of care is not a prerequisite for authorizing coverage.
 AND
- The member requires active treatment with 24-hour supervision/oversight by professional behavioral health staff that is not able to be provided at a less restrictive level of care.
AND
- ~~The setting is geographically situated to allow ongoing participation of the child's family.~~
AND
- ~~The child or adolescent attends a school in the community (e.g., a school integrated with children not from the group home and not on the group home's campus).~~
AND
- ~~The member remains involved in community-based activities and may attend educational, vocational or other treatments in the community.~~
AND
- ~~The TGH coordinates with the child's or adolescent's community resources, including schools, with the goal of transitioning the youth out of the program to a less restrictive care setting.~~
AND
- The member is not in imminent risk of harm to self or others and/or property.
AND
- Co-occurring behavioral health or physical conditions can be safely managed.

Continuing Stay Criteria

~~See Common Continuing Stay Criteria~~

- The admission criteria are still met.
AND
- Services continue to be medically necessary.
AND
- The precipitating factors leading to admission have been identified and are integrated into the treatment plan.
AND
- Best practices are being provided timely with sufficient intensity to address the member's needs.
AND
- Treatment is focused 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.
 - Decreasing problem behavior and increasing developmentally appropriate, normative and pro-social behavior.
 - Transitioning the child or adolescent from TGH to home or community-based living, with outpatient treatment (e.g., individual and family therapy).

Discharge Criteria

- ~~See Common Discharge Criteria~~

Clinical Best Practices

- ~~See Common Clinical Best Practices~~

REFERENCES

Louisiana Administrative Code, Title 50, Part I, Chapter 11, 2019. Retrieved from: <https://www.doa.la.gov/Pages/osr/lac/books.aspx>.

Louisiana Department of Health Behavioral Health Services Provider Manuals, 2019. Retrieved from:
<https://www.lamedicaid.com/provweb1/default.htm>.
https://www.lamedicaid.com/provweb1/Providermanuals/Intro_Page.aspx

Louisiana Department of Health Behavioral Health Services Provider Manual, Chapter Two: Behavioral Health Services, March (2017). Retrieved from:
<http://www.lamedicaid.com/provweb1/providermanuals/manuals/BHS/BHS.pdf>.

Louisiana Department of Health Behavioral Health Services Provider Manual, Chapter Four: Applied Behavior Analysis, October (2019). Retrieved from:
<http://www.lamedicaid.com/provweb1/providermanuals/manuals/BHS/BHS.pdf>.
<https://www.lamedicaid.com/provweb1/Providermanuals/manuals/ABA/ABA.pdf>.

Louisiana Department of Health and Hospitals and Louisiana Behavioral Health Partnership (LBHP) Service Definitions Manual, Version 9, July, (2014). Retrieved from:
http://www.dhh.louisiana.gov/assets/docs/BehavioralHealth/LBHP/2014_RFP_Procurement_Library/LBHP_Service_Definitions_Manual_8.15.14.pdf.

REVISION HISTORY

Date	Action/Description
05/09/2018	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Updates to the following per state language for 2019: <ul style="list-style-type: none"> Admission Common Criteria Assertive Community Treatment Admission Criteria Therapeutic Group Homes number of beds
XX/XX/2020	<ul style="list-style-type: none"> Update to add Evidence-Based Practice Criteria section and LOCUS/CASII/ECSII language

ⁱ Behavior treatment plan template can be found at www.lamedicaid.com. It is included in the Applied Behavior Analysis Provider Manual.

ⁱⁱ Face-to-face for CPST includes a therapist in a different room/location from the member/family, but in the same building, with real-time visual and audio transmission from the therapy room and two-way audio transmission between member and/or family member and therapist. Must be provided by licensed or qualified MA-level staff. MA-level staff must have appropriate licensed mental health professional oversight when providing treatment through real-time visual and audio transmission. The practice must be in accord with documented Evidence Based Practices or promising practices approved by the Office of Behavioral Health.

ⁱⁱⁱ According to Louisiana Administrative Code Subpart 13; Chapter 121(12103): The member is under the age of 21 and meets Medicaid eligibility and clinical criteria.