Mental Health Rehabilitation Services

The following provisions apply to all mental health rehabilitation (MHR) services for children, adolescents and adults, which include the following:

1. Community Psychiatric Support and Treatment (CPST);
2. Psychosocial Rehabilitation; and
3. Crisis Intervention.

These rehabilitation services are provided as part of a comprehensive specialized psychiatric program available to all Medicaid eligible children, adolescents and adults with significant functional impairments resulting from an identified mental health disorder diagnosis to promote the maximum reduction of symptoms and restoration to his/her best age-appropriate functional level.

Children and Adolescents

The expected outcome of rehabilitation services is restoration to a child/adolescent's best functional level by restoring the child/adolescent to their best developmental trajectory. This includes consideration of key developmental needs and protective factors such as:

1. Restoration of positive family/caregiver relationships;
2. Prosocial peer relationships;
3. Community connectedness/social belonging; and
4. The ability to function in a developmentally appropriate home, school, vocational and community settings.

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

Where children have parents with terminated parental rights or situations where parental involvement is contraindicated, the legal guardian should be involved.

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

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

Adults

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

Rehabilitation services are expected to achieve the following outcomes:

1. Assist individuals in the stabilization of acute symptoms of illness;

2. Assist individuals in coping with the chronic symptoms of their illness;

3. Minimize the aspects of their illness which makes it difficult for persons to live independently;

4. Reduce or prevent psychiatric hospitalizations;

5. Identify and develop strengths; and
6. Focus on recovery.

National Consensus Statement on Recovery – Recovery is a journey of healing and transformation enabling a person to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.

Ten components of recovery are as follows:

1. Self-Direction;

2. Individualized and Person Centered;

3. Empowerment;

4. Holistic;

5. Non-Linear;

6. Strengths-Based;

7. Peer Support;

8. Respect;

9. Responsibility; and

10. Hope.

Assessment for CPST and PSR

1. Each member must be assessed and must have a treatment plan developed based on that assessment;

2. Assessments must be performed by a licensed mental health provider (LMHP), and for children and adolescents must be completed with the involvement of the primary caregiver;

3. For adults, assessments must be performed prior to receiving CPST and/or PSR and at least once every 365 days until discharge. Assessments must also be performed any time there is a significant change to the member's circumstances. See Appendix G-2 for vocational and employment considerations; and

4. For youth, assessments must be performed prior to receiving CPST and/or PSR and at least once every 180 days until discharge. Assessments must also be performed any time there is a significant change to the member's circumstances. For additional details regarding conducting assessments for members 6 to 20 years of age, refer to Appendix G-1.

Treatment Plan Development for CPST and PSR

Treatment plans must be based on the member's assessed needs and developed by an LMHP or physician in collaboration with direct care staff, the member, family and natural supports. The treatment plan must contain goals and interventions targeting areas of risk and need identified in the assessment. All team members, including the member and family, must sign the treatment plan. The member must receive a copy of the plan upon completion. (If the member is too young to sign the treatment plan, a caregiver signature is sufficient to sign and receive the treatment plan).

The goal of the treatment plan is to help ensure measurable improved outcomes, increased strengths, a reduction in risk of harm to self or others, and a reduction emergency department use or in the risk of out of home placements to inpatient and residential care.

Based on an assessment/reassessment and informed by the member, parent/caregiver, the written treatment plan must include the following:

1. Goals and objectives that are specific, measurable, action oriented, realistic, and time-limited;

2. Specific interventions based on the assessed needs that must include reference to training material when delivering skills training;

3. Frequency and duration of services that will enable the member to meet the goals and outcomes identified in the treatment plan;

4. Services and interventions to support independent community living for transitioning adolescents and adults in the setting of his or her own choice and

must support integration in the community, including opportunities to seek employment, engage in community life, control personal resources, and improve functional skills at school, home or in the community;

5. Member's strengths, capacities, and preferences;

6. Clinical and support needs that are indicated by a psychosocial assessment, Child and Adolescent Level of Care Utilization System (CALOCUS) or Level of Care Utilization System (LOCUS) rating , and other standardized assessment tools as clinically indicated (See Appendix G.);

7. Place of service(s) for each intervention;

8. Staff type delivering each intervention;

9. Crisis avoidance interventions including the identification of risk factors and barriers with strategies to overcome them, including individualized back-up plans; and

10. Language written in a way that is clearly understandable by the member.

Treatment Plan Oversight

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

The member must receive a signed copy of the plan upon completion and after each revision. A copy of the treatment plan should also be sent to all of the individuals involved in implementing and monitoring the treatment plan. The treatment plan should not include services that are duplicative, unnecessary or inappropriate.

Monitoring Member Progress

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

1. Assessing mental health symptoms; and

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

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

Documentation

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

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

Eligibility Criteria

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

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

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

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

Adults must meet the Substance Abuse and Mental Health Services Administration (SAMHSA) definition of, serious mental illness (SMI) as evidenced by a rating of three or greater on the functional status domain on the Level of Care Utilization System (LOCUS) rating. In addition to having a diagnosable mental disorder, the condition must substantially interfere with, or limit, one or more major life activities, such as:

1. Basic daily living (for example, eating or dressing);

2. Instrumental living (for example, taking prescribed medications or getting around the community); and

3. Participating in a family, school, or workplace.

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

Service Utilization

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

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.

Determine the Appropriate Services and Level of Intensity

Prior to submitting an authorization request, the LMHP in collaboration with the member, family/caregiver, natural supports, and direct care staff must request services based on each member's assessment/reassessment, treatment history, treatment plan, progress toward accomplishing goals/objectives, level of member/family engagement, member choice/preference and level of need. The provider must ensure there is sufficient documentation to support the services requested.

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

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

Service Delivery

There must be member involvement throughout the planning and delivery of services. Services must be:

1. Delivered in a culturally and linguistically competent manner;

2. Respectful of the individual receiving services;

3. Appropriate to individuals of diverse racial, ethnic, religious, sexual and gender identities and other cultural and linguistic groups; and

4. Appropriate for age, development, and education.

Anyone providing mental health services must operate within their scope of practice license. Evidence-based practices require prior approval and fidelity review on an ongoing basis as determined necessary by the Department.

Active Intervention vs. Observation

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

Service Location

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

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

The following are required when services are delivered at school:

1. The initial and ongoing assessment must indicate school related needs, which may include, but is not limited to, disruptive behaviors in school, poor school attendance, and difficulties with social and peer interactions in school;

2. Prior to MHR services being delivered in the school setting, each member must be assessed by an LMHP. This assessment must include a review of school records and interviews with school personnel. Ongoing reassessment of need must be

conducted by an LMHP to determine if services must continue with school as a place of service;

3. MHR providers must collaborate with school personnel to collect data to monitor a member's progress. Data collection may include standardized tools as well as collecting other information to determine if a member is making progress. This must be documented in the member's record. Data collection is not billable;

4. The member must not be removed from a core class such as math, science, or English, without written permission from the parent and school personnel. A rationale must be documented in the member's record. If allowed by the member's school, direct interventions may be delivered in the classroom if medically necessary and on the member's treatment plan. Only observing a member is not billable;

5. Prior to delivering services in a member's school, the provider must obtain written approval from the school. The written approval must be filed in the member's record; and

6. Providers delivering services in a member's school must actively communicate and coordinate services with school personnel and with the member's family/caregiver to avoid service duplication.

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

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

Delivering Services to Family Members

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

1. First-degree relatives include parents, spouses, siblings, and children;

2. Second-degree relatives include grandparents, grandchildren, aunts, uncles, nephews, and nieces;

3. Third-degree relatives include great-grandparents, great-grandchildren, great aunts, great uncles, and first cousins; and

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

Member Choice Form and Process

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

1. A member is receiving tenancy support through the Permanent Supportive Housing Program; and/or

2. The behavioral health medical director for the member's health plan makes the determination that it is medically necessary and clinically appropriate to receive services from more than one MHR provider. The justification must be supported by the member's assessment and treatment plan. This decision must be reviewed at each reauthorization. If a member is receiving services from more than one MHR provider, the providers must have documented coordination of care.

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

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

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

Provider Responsibilities

1. All services must be delivered in accordance with federal and state laws and regulations, the provider manual and other notices or directives issued by the Department. The provider must create and maintain documents to substantiate that all requirements are met. (See Section 2.6 of this manual chapter regarding record keeping);

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

3. Any licensed practitioner providing mental health services must operate within their scope of practice license; and

4. Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR) services provided by staff (holding an individual National Provider Identifier) regardless of employment at multiple agencies must be limited to a maximum combined total of twelve (12) reimbursable hours of CPST services and PSR services within a calendar day:

    a. The twelve-(12) hour limitation must not apply per individual behavioral health services provider agency, rather it applies per individual rendering provider;

    b. The twelve-(12) hour limitation must not apply to evidence-based practices; and

    c. There is a maximum combined total of twelve (12) reimbursable hours of CPST services and PSR services unless any of the following conditions are met:

i. The medical necessity of the services is documented through the prior authorization approval for a Medicaid recipient receiving more than twelve (12) hours of CPST and PSR services;

ii. The services are billed for a group setting and the total hours worked by an individual rendering provider does not exceed twelve (12) hours per calendar day; or

~~i.~~iii. The services are billed for crisis intervention.

Core Services

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

1. Assessment;
2. Orientation;
3. Treatment;
4. Client education;
5. Consultation with professionals;
6. Counseling services;
7. Referral;
8. Rehabilitation services;
9. Crisis mitigation services; and
10. Medication management.

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

The BHSP Crisis Mitigation Plan

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

The BHSP's crisis mitigation plan must include the following:

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

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

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

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

Core Staffing

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

The minimum core staffing requirements are:

1. Medical Director/Clinical Director;
2. Administrator;
3. Clinical Supervisor; and
4. Nursing Staff.

Medical Director

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

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

The medical director has the following assigned responsibilities:

1. Ensures that necessary medical services are provided that meet the needs of the clients;

2. Provides oversight for provider policy/procedure, client treatment plans, and staff regarding the medical needs of the clients according to the current standards of medical practice;

3. Directs the specific course of medical treatment for all clients;

4. Reviews reports of all medically related accidents/incidents occurring on the premises and identifies hazards to the administrator;

5. Participates in the development and implementation of policies and procedures for the delivery of services;

6. Periodically reviews delivery of services to ensure care meets the current standards of practice; and

7. Participates in the development of new programs and modifications.

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

1. Writes the admission and discharge orders;

2. Writes and approves all prescription medication orders;

3. Develops, implements and provides education regarding the protocols for administering prescription and non-prescription medications on-site;

4. Provides consultative and on-call coverage to ensure the health and safety of clients; and

5. Collaborates with the client's primary care physician as needed for continuity of the client's care.

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

Clinical Director

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

1. Be a licensed psychiatrist, licensed psychologist, licensed clinical social worker (LCSW), licensed professional counselor (LPC), or licensed marriage and family therapist (LMFT) with a minimum of two years qualifying experience in treating psychiatric disorders and who maintains a current, unrestricted license to practice in the state of Louisiana;

2. Have the following assigned responsibilities:

   a. Ensures that the necessary services are provided to meet the needs of the clients;

   b. Provides oversight for the provider policy/procedure, treatment planning, and staff regarding the clinical needs of the clients according to the current standards of clinical practice;

   c. Directs the course of clinical treatment for all clients;

d. Reviews reports of all accidents/incidents occurring on the premises and identifies hazards to the Administrator;

e. Participates in the development and implementation of policies and procedures for the delivery of services;

f. Periodically reviews delivery of services to ensure care meets the current standards of practice; and

g. Participates in the development of new programs and modifications.

3. Have the following responsibilities or designates the duties to a qualified practitioner:

a. Provides consultative and on-call coverage to ensure the health and safety of clients; and

b. Collaborates with the client's primary care physician and psychiatrist as needed for continuity of the client's care.

Administrator

An Administrator must:

1. Possess either a bachelor's degree from an accredited college or university or one year of qualifying experience that demonstrates knowledge, experience and expertise in business management;

2. Be responsible for the on-site day to day operations of the BHSP and supervision of the overall BHSP's operation; and

3. Not perform any programmatic duties and/or make clinical decisions unless licensed to do so.

Clinical Supervisor

A Clinical Supervisor must:

1. Be a fully licensed LMHP that maintains a current and unrestricted license with its respective professional board or licensing authority in the state of Louisiana;

2. Be on duty and on call as needed;

3. Have a minimum of two years qualifying experience as an LMHP in the provision of services provided by the BHSP; and

4. Have the following responsibilities:

    a. Provides supervision utilizing evidence-based techniques related to the practice of behavioral health counseling;

    b. Serves as resource person for other professionals counseling or providing direct services to clients with behavioral health disorders;

    c. Attends and participates in treatment planning activities and discharge planning;

    d. Functions as client advocate in treatment decisions;

    e. Ensures BHSP adheres to rules and regulations regarding all behavioral health treatment, such as group size, caseload and referrals; and

    f. Assists the Medical Director with the development and implementation of policies and procedures.

Mental Health Supervisor

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

1. Be a fully licensed physician, or currently licensed and in good standing in the state of Louisiana to practice within the scope of all applicable state laws, practice acts, and the individual's professional license, as one of the following:

    a. Medical psychologist;

    b. Licensed psychologist;

    c. Licensed clinical social worker (LCSW);

    d. Licensed professional counselor (LPC);

    e. Licensed marriage and family therapist (LMFT); or

    f. Licensed advanced practice registered nurse (APRN) in adult psychiatric and mental health, and family psychiatric and mental health, or certified nurse specialists in psychosocial, gerontological psychiatric mental health, adult psychiatric and mental health and child-adolescent mental health.

2. Be employed by the BHSP for at least 35 (thirty-five) hours per week; and

3. Assist in the design and evaluation of treatment plans for PSR and CPST services.

Nursing Staff

Nursing Staff must:

1. Provide nursing care and services under the direction of a registered nurse necessary to meet the needs of clients;

2. Have a valid current nursing license in the state of Louisiana; and

3. Meet the medication needs of clients of the BHSP who are unable to self-administer medication, if needed.

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

Staff Supervision for Non-Licensed Staff

Provisionally Licensed Professional Counselor (PLPC), Provisionally Licensed Marriage and Family Therapist (PLMFT), Licensed Master Social Worker (LMSW), Certified Social Worker (CSW) or a psychology intern from an APA approved internship program delivering CPST and/or PSR, services must be under regularly scheduled supervision in accordance with requirements established by the practitioner's professional licensing board. Proof of the board approved supervision must be held by the MHR agency employing these staff. For the psychology intern, the supervisory plan is acceptable. In addition, these staff who only provide CPST or PSR must receive at least one hour per calendar month of personal supervision and training by the provider agency's mental health supervisor pursuant to La. R.S. 40:2162, et seq. and must be documented according to the requirements listed in numbers 2 and 3 below.

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

Non-licensed staff providing CI (excluding psychology interns) must receive regularly scheduled supervision from a person meeting the qualifications of a psychiatrist or an LMHP (excluding Licensed Addiction Counselors (LACs)). Psychiatrist/LMHP supervisors must have the practice-specific education, experience, training, credentials, and licensure to coordinate an array of mental and/or behavioral health services. Agencies may have more than one psychiatrist/LMHP

supervisor providing required supervision to non-licensed staff. However, the agency must designate one Clinical Supervisor to fulfill the roles and responsibilities established for the Clinical Supervisor position in the Core Staffing section above. A psychiatrist/LMHP supervisor may act in the role of the provider agency's Clinical Supervisor if the individual is qualified to fulfill both roles.

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

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

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

Group supervision means one LMHP supervisor (excluding LACs) and not more than six (6) supervisees in supervision session.

Texts and/or emails cannot be used as a form of supervision to satisfy this requirement. All protected health information discussed during supervision must be HIPAA compliant.

The supervision with the LMHP must:

1. Occur before initial services on a new member begin and, at a minimum, twice a month preferably every fifteen (15) days (except under extenuating or emergent circumstances that are reflected in the supervisory notes);

2. Progress notes that are discussed in supervision must have the LMHP supervisor signature; and

3. Have documentation reflecting the content of the training and/or clinical guidance. The documentation must include the following:

    a. Date and duration of supervision;

    b. Identification of supervision type as individual or group supervision;

    c. Name and licensure credentials of the LMHP supervisor;

    d. Name and credentials (provisionally licensed, master's degree, bachelor's degree, or high school degree) of the supervisees;

    e. The focus of the session and subsequent actions that the supervisee must take;

    f. Date and signature of the LMHP supervisor;

    g. Date and signature of the supervisees;

    h. Member identifier, service and date range of cases reviewed; and

    i. Start and end time of each supervision session.

Limitations/Exclusions

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

1. Components that are not provided to, or directed exclusively toward, the treatment of the Medicaid eligible individual;

2. Services provided at a work site, which are job-oriented and not directly related to the treatment of the member's needs;

3. These rehabilitation services must not duplicate any other Medicaid State Plan service or service otherwise available to the member at no cost; and

4. Any services or components in which the basic nature of which are to supplant housekeeping, homemaking, or basic services for the convenience of an individual receiving services.

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

1. Activities provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide, or an academic tutor;

2. Child care provided as a substitute for the parent or other individuals responsible for providing care and supervision;

3. Respite care;

4. Teaching job related skills (management of symptoms and appropriate work habits may be taught);

5. Vocational rehabilitation (vocational assessment, job development, job coaching); CPST and PSR can include services, such as interpersonal skills, anger management, etc.) that enable the beneficiary to function in the workplace;

6. Transportation;

7. Staff training;

8. Phone contacts including attempts to reach the member by telephone to schedule, confirm, or cancel appointments;

9. Staff supervision;

10. Completion of paper work when the member and/or their significant others are not present. Requiring members to be present only for documentation purposes is not reimbursable;

11. Team meetings and collaboration exclusively with staff employed or contracted by the provider where the member and/or their family/caregivers are not present;

12. Observation of the member (e.g. in the school setting or classroom);

13. Staff research on behalf of the member;

14. Providers may not set up summer camps and bill the time as a mental health rehabilitation service;

15. All contacts by salaried professionals such as supervisors, administrators, human resources staff, receptionists, etc. that are included in the rate (including meetings, travel time, etc.), are considered indirect costs;

16. Contacts that are not medically necessary;

17. Covered services that have not been rendered;

18. Services rendered that are not in accordance with an approved authorization;

19. Interventions not identified in the member's treatment plan;

20. Services provided to children, spouse, parents, or siblings of the eligible member under treatment or others in the eligible member's life to address problems not directly related to the eligible member's issues and not listed on the member's treatment plan;

21. Services provided that are not within the provider's scope of practice;

22. Any art, movement, dance, or drama therapies; and

23. Any intervention or contact not documented.

Community Psychiatric Support and Treatment

Community Psychiatric Support and Treatment (CPST) is a goal-directed support and solution-focused intervention, which focuses on reducing the disability resulting from mental illness,

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

Components Performed by an LMHP

1. **Initial and annual assessment**, including the LOCUS/CALOCUS; and

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

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

1. **Ongoing monitoring of needs** including triggering an update of the treatment plan by the LMHP if needs change significantly;

2. **Counseling**, including mental health interventions that address symptoms, behaviors, thought processes,that assist the member in eliminating barriers to treatment and identifying triggers. Counseling includes assisting the member with effectively responding to or avoiding identified precursors or triggers that would

impact the member's ability to remain in a natural community location. The use of evidenced based practices/strategies is encouraged; and

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

CPST Allowed Provider Types and Specialties

1. PT 77 Mental Health Rehab PS 78 MHR; and

2. PT 74 Mental Health Clinic PS 70 Clinic / Group PSS 8E CSoC/ Behavioral Health.~~;~~

~~PT AG Behavioral Health Rehabilitation Provider Agency PS 8E CSoC/ Behavioral Health.~~

CPST Allowed Mode(s) of Delivery

1. Individual;

2. On-site; and

3. Off-site.

CPST Additional Service Criteria

Research-based and evidence-based practices (EBPs) may be billed using a combination of codes for licensed practitioners and, CPST, and are subject to prior authorization. The EBPs must be consistent with the CPST State Plan definition.

CPST Staff Ratio(s)

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

CPST Provider Qualifications

Agency

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

1. Licensed – pursuant to La. R.S. 40:2151, *et seq*.;

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

    a. All provider agencies regardless of when they were contracted with a Medicaid managed care entity must be fully accredited or obtain a preliminary accreditation prior to contracting with a Medicaid managed care entity or rendering CPST services. Agencies must provide proof of full accreditation or preliminary accreditation to each managed care entity with which it is contracted; and

    b. Agencies must maintain proof of continuous, uninterrupted full accreditation or preliminary accreditation at all times. Agencies providing CPST services must obtain a full accreditation status within eighteen (18) months of the agency's preliminary accreditation date and must provide proof of full accreditation once obtained to each managed care entity with which it is contracted.

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

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

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

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

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

    d. Any other applicable state or federal law.

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

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

Medicare Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General;

NOTE: Providers are required to maintain results in personnel records that checks have been completed. The OIG maintains the LEIE on the OIG website and LDH maintains the Adverse Action website. (See Appendix A).

6. Establishes and maintains written policies and procedures inclusive of drug testing staff to ensure an alcohol and drug-free workplace and a workforce free of substance use. (See Appendix D);

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

8. Maintains documentation of verification of completion of required trainings for all staff;

9. Ensures and maintains documentation that all non-licensed persons employed by the organization complete training in a recognized crisis intervention curriculum prior to handling or managing crisis responses, which must be updated annually;

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

11. Must be credentialed and participating (contracted) in the provider network of the Medicaid managed care entity to be eligible to receive Medicaid reimbursement unless the provider agency is licensed and accredited, and has an executed single case agreement with the Medicaid managed care entity. Providers that meet the provisions of La. R.S. 40:2154.1

Providers that meet the provisions of La. R.S. 40:2154.1 must have submitted a completed license application by December 1, 2017, and must have become licensed by LDH Health Standards as a BHSP by April 1, 2018. Providers that submit a completed license application to LDH Health

Standards by December 1, 2017, may continue to operate/provide services and may continue to participate in the Louisiana Medicaid Program during the pendency of the license application process (assuming that all other Medicaid requirements are met); however, such providers must receive a BHSP license issued by LDH Health Standards by April 1, 2018 in order to continue operation and in order to continue to participate in the Louisiana Medicaid Program and receive Medicaid payments.

Providers that meet one of applicability exemptions of La. R.S. 40:2154

Providers who meet one of applicability exemptions of the BHSP licensing statute, La. R.S. 40:2154, are required to obtain a BHSP license or other agency license issued by LDH Health Standards by April 1, 2018, in order to continue to participate in the Louisiana Medicaid Program and receive Medicaid payments. Such provider may continue to be reimbursed by Medicaid until April 1, 2018, provided that the provider complies with all other Medicaid requirements. Beginning April 1, 2018, if such provider does not have a BHSP license or other agency license issued by LDH Health Standards, the provider may no longer participate in the Louisiana Medicaid Program or receive Medicaid payments.

Notwithstanding the above paragraph:

1. A licensed Home and Community-Based Service Provider may not perform CPST services unless it also has a BHSP license issued by LDH Health Standards; and

2. A school based health clinic/center or community mental health center may not perform CPST services unless it also has a BHSP license issued by LDH Health Standards.

Federally Qualified Health Centers

A federally qualified health center (FQHC) that provides CPST services under an agreement with a federal department/agency pursuant to federal law and regulation and pursuant to the provider's approved scope of work for ambulatory services, is **NOT** required to obtain a BHSP license issued by LDH Health Standards; however, in this situation, the FQHC must only utilize practitioners approved via the Medicaid FQHC Provider Manual, i.e. psychiatrists, licensed clinical psychologists, and licensed clinical social workers, and must bill under its all-inclusive Prospective Payment System (PPS) rate and FQHC Medicaid provider number in accordance with the FQHC Medicaid Rules, policies, and manuals.

An FQHC that provides CPST services separate from an agreement with a federal department/agency pursuant to federal law and regulation and separate from its approved scope of work for ambulatory services, is required to obtain a BHSP license issued by LDH Health Standards. In this situation, the entity must enroll as an appropriate Specialized Behavioral Health Services (SBHS) provider type with a unique National Provider Identifier (NPI), must have active BHSP licensure issued by LDH Health Standards, and must bill under its unique BHSP NPI in accordance with the Behavioral Health Medicaid Rules, Policies, and Manuals.

Staff

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

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

1. Individuals rendering the assessment and treatment planning components of CPST services must be an LMHP.

2. Effective January 1, 2023, individuals rendering all other components of CPST services must be an LMHP, Provisionally Licensed Professional Counselor (PLPC), Provisionally Licensed Marriage and Family Therapist (PLMFT), Licensed Master Social Worker (LMSW), Certified Social Worker (CSW) or a psychology intern from an APA approved internship program.

   NOTE – STAFF OF EVIDENCE BASED PROGRAMS: It is LDH's position that staff qualifications established by Act 503 of the 2022 Regular Legislative Session are not inclusive of LDH's recognized mental health rehabilitation evidence based programs (EBPs). LDH acknowledges the importance of staff qualifications aligning with EBP model requirements, recommendations and guidelines in order to adhere to the fidelity of these models. LDH recognizes the following programs as evidence based. Agencies providing these EBP services must ensure their staff adhere to qualifications and requirements established by the EBP model: Assertive Community Treatment (ACT), Functional Family Therapy (FFT and FFT-CW), Homebuilders®, Multi-Systemic Therapy (MST) and Permanent Supportive Housing (PSH). For more information on PSH requirements, please refer to the Permanent Supportive Housing website under the LDH Office of Aging and Adult Services (OAAS).

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

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

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

6. Pass drug screening tests as required by agency's policies and procedures.

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

8. Individuals rendering CPST services for the licensed and accredited provider agency must have an NPI number and that NPI number must be included on any claim submitted by that provider agency for reimbursement.

Telehealth (effective May 1, 2023)

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

The 'originating site' means the location of the member at the time the telehealth services are provided. Except for the service area restrictions of licensed behavioral health services providers in accordance with LAC. Tit. 48.I. 5605 M., or current applicable regulations, there is no restriction on the originating site and it can include, but is not limited to, a healthcare facility, school, or the member's home. 'Distant site' means the site at which the physician or other licensed practitioner is located at the time the telehealth services are provided.
CPST may be provided via telecommunication technology when the following criteria is met:

1. The telecommunication system used by physicians, LMHPs and other qualified professional must be secure, ensure member confidentiality, and be compliant with

the requirements of the Health Insurance Portability and Accountability Act (HIPAA);

2. The services provided are within the practitioner's telehealth scope of practice as dictated by the respective professional licensing board and accepted standards of clinical practice;

3. The member's record includes informed consent for services provided through the use of telehealth;

4. Services provided using telehealth must be identified on claims submission using by appending the modifier "95" to the applicable procedure code and indicating the correct place of service, either POS 02 (other than home) or 10 (home). Both the correct POS and the 95 modifier must be present on the claim to receive reimbursement;

5. Assessments and treatment planning conducted by an LMHP through telehealth shall include synchronous, interactive, real-time electronic communication comprising both audio and visual elements unless clinically appropriate and based on member consent; and

6. Providers must deliver in-person services when telehealth is not clinically appropriate or when the member prefers in-person services. The provider must document the member's preference for in-person or telehealth.

Psychosocial Rehabilitation

Psychosocial rehabilitation (PSR) services are designed to assist the individual with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their mental illness. Activities included must be intended to achieve the identified goals or objectives as set forth in the individual's individualized treatment plan. The intent of PSR is to restore the fullest possible integration of the individual as an active and productive member of his or her family, community and/or culture with the least amount of ongoing professional intervention. PSR is a face-to-face intervention with the individual present. Services may be provided individually or in a group setting. Most contacts occur in community locations where the person lives, works, attends school and/or socializes.

Psychosocial rehabilitation must be manualized or delivered in accordance with a nationally accepted protocol. PSR is directed toward a particular symptom and works on increasing or reducing a particular behavior.

Components

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

2. **Supporting the restoration and rehabilitation of 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; and

3. **Supporting the restoration and rehabilitation of daily living skills** to improve self-management of the negative effects of psychiatric or emotional symptoms that interfere with a person's daily living. Supporting the individual with development and implementation of daily living skills and daily routines necessary to remain in home, school, work and community.

PSR Allowed Provider Types and Specialties

1. PT 77 Mental Health Rehab PS 78 MHR; and

2. PT 74 Mental Health Clinic PS 70 Clinic / Group PSS 8E CSoC/ Behavioral Health.~~;~~

~~2. PT AG Behavioral Health Rehabilitation Provider Agency PS 8E CSoC/ Behavioral Health.~~

PSR Allowed Mode(s) of Delivery

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

PSR Staff Ratio(s)

The maximum group sizes are as follows:

1. One Full Time Employee (FTE) to fifteen (15) consumers is maximum group size for adults; and
2. One FTE to eight (8) consumers is maximum group size for youth.

PSR Provider Qualifications

Agency

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

1. Be licensed pursuant to La. R.S. 40:2151, *et seq*.;
2. Be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or The Joint Commission (TJC). Providers must report any denial, loss of, or any negative change in accreditation status, e.g. suspension, reduction in accreditation status, etc. in writing within twenty-four (24) hours of receipt of notification of such denial, loss of, or any negative change in accreditation status to the managed care entities with which the agency contracts or is being reimbursed;
    a. All provider agencies regardless of when they were contracted with a Medicaid managed care entity must be fully accredited or obtain a preliminary accreditation prior to contracting with a Medicaid managed care entity or rendering PSR services. Agencies must provide proof of full accreditation or preliminary accreditation to each managed care entity with which it is contracted. Agencies must maintain proof of continuous,

uninterrupted full accreditation or preliminary accreditation at all times. Agencies providing PSR services must obtain a full accreditation status within eighteen (18) months of the agency's preliminary accreditation date and must provide proof of full accreditation once obtained to each managed care entity with which it is contracted.

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

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

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

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

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

    d. Any other applicable state or federal law.

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

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

   NOTE: Providers are required to maintain results in personnel records that checks have been completed. The OIG maintains the LEIE on the OIG website and LDH maintains the Adverse Action website. (See Appendix A).

6. Establishes and maintains written policies and procedures inclusive of drug testing staff to ensure an alcohol and drug-free workplace and a workforce free of substance use. (See Appendix D);

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

8. Maintains documentation of verification of completion of required trainings for all staff;

9. Ensures and maintains documentation that all non-licensed persons employed by the organization complete training in a recognized crisis intervention curriculum prior to handling or managing crisis responses, which must be updated annually;

10. Has a National Provider Identification (NPI) number, and must include the agency NPI number and the NPI number of the individual rendering PSR services on its behalf on

all claims for Medicaid reimbursement for dates of service on or after January 1, 2019; and

11. Must be credentialed and participating (contracted) in the provider network of the Medicaid managed care entity to be eligible to receive Medicaid reimbursement unless the provider agency is licensed and accredited, and has an executed single case agreement with the Medicaid managed care entity.

Providers that meet the provisions of La. R.S. 40:2154.1

Providers that meet the provisions of La. R.S. 40:2154.1 must have submitted a completed license application by December 1, 2017, and must have become licensed by LDH Health Standards as a BHSP by April 1, 2018. Providers that submit a completed license application to LDH Health Standards by December 1, 2017, may continue to operate/provide services and may continue to participate in the Louisiana Medicaid Program during the pendency of the license application process (assuming that all other Medicaid requirements are met); however, such providers must receive a BHSP license issued by LDH Health Standards by April 1, 2018 in order to continue operation and in order to continue to participate in the Louisiana Medicaid Program and receive Medicaid payments.

Providers that meet one of the applicability exemptions of La. R.S. 40:2154

Providers who meet one of applicability exemptions of the BHSP licensing statute, La. R.S. 40:2154, are required to obtain a BHSP license or other agency license issued by LDH Health Standards by April 1, 2018, in order to continue to participate in the Louisiana Medicaid Program and receive Medicaid payments. Such provider may continue to be reimbursed by Medicaid until April 1, 2018, provided that the provider complies with all other Medicaid requirements. Beginning April 1, 2018, if such provider does not have a BHSP license or other agency license issued by LDH Health Standards, the provider may no longer participate in the Louisiana Medicaid Program or receive Medicaid payments.

Notwithstanding the above paragraph:

1. A licensed Home and Community-Based Service provider may not perform PSR services unless it also has a BHSP license issued by LDH Health Standards; and

2. A school based health clinic/center or community mental health center may not perform PSR services unless it also has a BHSP license issued by LDH Health Standards.

Federally Qualified Health Centers

A federally qualified health center (FQHC) that provides psychosocial rehabilitation services under an agreement with a federal department/agency pursuant to federal law and regulation and pursuant to the provider's approved scope of work for ambulatory services, is **NOT** required to obtain a BHSP license issued by LDH Health Standards; however, in this situation, the FQHC must only utilize practitioners approved via the Medicaid FQHC Provider Manual, i.e. psychiatrists, licensed clinical psychologists, and licensed clinical social workers, and must bill under its all-inclusive Prospective Payment System (PPS) rate and FQHC Medicaid provider number in accordance with the FQHC Medicaid Rules, policies, and manuals.

An FQHC that provides psychosocial rehabilitation services separate from an agreement with a federal department/agency pursuant to federal law and regulation and separate from its approved scope of work for ambulatory services, is required to obtain a BHSP license issued by LDH Health Standards. In this situation, the entity must enroll as an appropriate SBHS provider type with a unique National Provider Identifier (NPI), must have active BHSP licensure issued by LDH Health Standards, and must bill under its unique BHSP NPI in accordance with the Behavioral Health Medicaid Rules, Policies, and Manuals.

Staff

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

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

1. Any individual rendering PSR services for a licensed and accredited provider agency must meet the following qualifications:

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

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

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

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

2. Satisfactory completion of criminal background check pursuant to the BHSP licensing regulations (LAC 48:I.Chapter 56), La. R.S. 40:1203.1 *et seq*., La R.S. 15:587 (as applicable), and any applicable state or federal law or regulation;
3. Employees and contractors must not be excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General;

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

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

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

7. Non-licensed direct care staff are required to complete a basic clinical competency training program approved by the Office of Behavioral Health (OBH) prior to providing the service. (See Appendix D);

8. Individuals rendering PSR services for the licensed and accredited provider agency must have an NPI number and that NPI number must be included on any claim submitted by that provider agency for reimbursement; and

Crisis Intervention

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

Components

The components of Crisis Intervention services are as follows:

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

2. Short-term CIs, including crisis resolution and debriefing with the identified Medicaid-eligible individual;

3. Follow up with the individual and, as necessary, with the individuals' caretaker and/or family members; and

4. Consultation with a physician or with other qualified providers to assist with the individuals' specific crisis.

   NOTE: The components above are required unless the member is not available due to incarceration, hospitalization, or other unavoidable reason.

CI Eligibility Criteria

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

All individuals who self-identify as experiencing a seriously acute psychological/emotional change, which results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved to effectively resolve it, are eligible.

CI Service Utilization

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 assessment of risk, mental status and medical stability must be completed by an LMHP with experience regarding this specialized mental health service, practicing within the scope of their professional license; and

The time spent by the LMHP during face-to-face time with the member is billed separately using CPT codes. 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.

CI Allowed Provider Types and Specialties

1. PT 77 Mental Health Rehab PS 78 MHR; and

~~1.~~ PT 74 Mental Health Clinic PS 70 Clinic / Group PSS 8E CSoC/ Behavioral Health.~~;~~ ~~and~~

~~1.~~

~~1. PT AG Behavioral Health Rehabilitation Provider Agency PS 8E CSoC/ Behavioral Health.~~

CI Allowed Mode(s) of Delivery

1. Individual;

2. On-site; and

3. Off-site.

CI Additional Service Criteria

An individual in crisis may be represented by a family member or other collateral contact that has knowledge of the individual's capabilities and functioning. Individuals in crisis who require this service may be using substances during the crisis, and this will not, in and of itself, disqualify them for eligibility for the service.

Substance use should be recognized and addressed in an integrated fashion, as it may add to the risk, increasing the need for engagement in care.

The crisis plan developed by the non-licensed professional, in collaboration with the treatment team and LMHP, must be provided under the supervision of an LMHP with experience regarding this specialized mental health service. The LMHP must be available at all times to provide back up, support and/or consultation from assessment of risk and through all services delivered during a crisis.

CI Provider Qualifications

Agency

To provide crisis intervention services, the agency must meet the following requirements:

1. Be licensed pursuant to La. R.S. 40:2151, *et seq*.;

2. Be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or The Joint Commission (TJC). Denial, loss of, or any negative change in accreditation status must be reported in writing immediately upon notification to the managed care entities with which the agency contracts or is being reimbursed;

   NOTE: Agencies must apply for accreditation and pay accreditation fees prior to being contracted and reimbursed by a Medicaid managed care entity, and must maintain proof of accreditation application and fee payment. Agencies must attain full accreditation within eighteen (18) months of the initial accreditation application date.

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

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

    b. La. R.S. 40:1203.1 *et seq*. associated with criminal background checks of un-licensed workers providing patient care;
    c. La. R.S. 15:587, as applicable; and

    d. Any other applicable state or federal law.

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

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

or Medicare Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General;

NOTE: Providers are required to maintain results in personnel records that checks have been completed. The OIG maintains the LEIE on the OIG website and LDH maintains the Adverse Action website. (See Appendix A).

7. Establishes and maintains written policies and procedures inclusive of drug testing staff to ensure an alcohol and drug-free workplace and a workforce free of substance use. (See Appendix D);

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

9. Maintains documentation of verification of completion of required trainings for all staff; and

10. Ensures and maintains documentation that all non-licensed persons employed by the organization complete training in a recognized Crisis Intervention curriculum prior to handling or managing crisis responses, which must be updated annually.

Providers that meet the provisions of La. R.S. 40:2154.1

Providers that meet the provisions of La. R.S. 40:2154.1 must have submitted a completed license application by December 1, 2017, and must have become licensed by LDH Health Standards as a BHSP by April 1, 2018. Providers that submit a completed license application to LDH Health Standards by December 1, 2017, may continue to operate/provide services and may continue to participate in the Louisiana Medicaid Program during the pendency of the license application process (assuming that all other Medicaid requirements are met); however, such providers must receive a BHSP license issued by LDH Health Standards by April 1, 2018 in order to continue operation and in order to continue to participate in the Louisiana Medicaid Program and receive Medicaid payments.

Providers that meet one of applicability exemptions of La. R.S. 40:2154

Providers who meet one of applicability exemptions of the BHSP licensing statute, La. R.S. 40:2154, are required to obtain a BHSP license or other agency license issued by LDH Health Standards by April 1, 2018, in order to continue to participate in the Louisiana Medicaid Program and receive Medicaid payments. Such provider may continue to be reimbursed by Medicaid until April 1, 2018, provided that the provider complies with all other Medicaid requirements. Beginning April 1, 2018, if such provider does not have a BHSP license or other agency license issued by LDH Health Standards, the provider may no longer participate in the Louisiana Medicaid Program or receive Medicaid payments.

Notwithstanding the above paragraph, the following also applies:

1. A licensed Home and Community-Based Service Provider may not perform CI services unless it also has a BHSP license issued by LDH Health Standards; and

2. A school based health clinic/center or community mental health center may not perform CI services unless it also has a BHSP license issued by LDH Health Standards.

Federally Qualified Health Centers

A federally qualified health center (FQHC) that provides crisis intervention services under an agreement with a federal department/agency pursuant to federal law and regulation and pursuant to the provider's approved scope of work for ambulatory services, is **NOT** required to obtain a BHSP license issued by LDH Health Standards; however, in this situation, the FQHC must only utilize practitioners approved via the Medicaid FQHC Provider Manual, i.e. psychiatrists, licensed clinical psychologists, and licensed clinical social workers, and must bill under its all-inclusive Prospective Payment System (PPS) rate and FQHC Medicaid provider number in accordance with the FQHC Medicaid Rules, policies, and manuals.

An FQHC that provides crisis intervention services separate from an agreement with a federal department/agency pursuant to federal law and regulation and separate from its approved scope of work for ambulatory services, IS required to obtain a BHSP license issued by LDH Health Standards. In this situation, the entity must enroll as an appropriate SBHS provider type with a unique National Provider Identifier (NPI), must have active BHSP licensure issued by LDH Health Standards, and must bill under its unique BHSP NPI in accordance with the Behavioral Health Medicaid Rules, Policies, and Manuals.

Staff

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

Staff must also meet the following requirements:

1. Be at least 20 years old and have an associate's degree in social work, counseling, psychology or a related human services field or two years of equivalent education and/or experience working in the human services field. The Human Service field is defined as an academic program with a curriculum content in which at least 70 percent of the required courses are in the study of behavioral health or human behavior. Additionally, the staff must be at least three years older than an individual under the age of eighteen (18).

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

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

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

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

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

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

7. Non-licensed direct care staff are required to complete a basic clinical competency training program approved by OBH prior to providing the service. (See Appendix D); and

8. Complete a recognized crisis intervention training.