

§6103. Recipient Qualifications

A. Individuals, 21 years of age and older, who meet Medicaid eligibility and clinical criteria established in §6103.B, shall qualify to receive adult mental health services.

B. Qualifying individuals shall be eligible to receive the following adult mental health services.

1. Licensed mental health professional services are available to adults enrolled in Bayou Health, provided the services are determined to be medically necessary in accordance with LAC 50:I.1101.

2. Mental health rehabilitation services are available to adults enrolled in Bayou Health, provided the services are

determined to be medically necessary in accordance with LAC 50:I.1101, and the enrollee meets the following conditions:

a. currently presents with mental health symptoms that are consistent with a diagnosable mental disorder specified within the *Diagnostic and Statistical Manual of Mental Disorders (DSM-V)* or the *International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10)*;

b. has at least a score of two on the level of care utilization system (LOCUS); and

c. has a condition for which services are therapeutically appropriate.

C. An adult who has previously met the criteria stated in §6103.B.2.a-c, but who now meets a composite LOCUS score of one and needs subsequent medically necessary services for stabilization and maintenance, shall be eligible for adult mental health services.

D. An adult with a primary diagnosis of a substance use disorder without an additional co-occurring qualifying mental health diagnosis shall not meet the criteria for mental health rehabilitation services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:358 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:378 (February 2015), LR 42:60 (January 2016).

Chapter 63. Services

§6301. General Provisions

A. All mental health services must be medically necessary, in accordance with the provisions of LAC 50:I.1101. The medical necessity for services shall be determined by a licensed mental health practitioner or physician who is acting within the scope of his/her professional license and applicable state law.

B. All services shall be prior authorized. Services which exceed the initial authorization must be approved for re-authorization prior to service delivery.

C. There shall be recipient involvement throughout the planning and delivery of services.

1. Services shall be:

a. delivered in a culturally and linguistically competent manner; and

b. respectful of the individual receiving services.

2. Services shall be appropriate to individuals of diverse racial, ethnic, religious, sexual, and gender identities and other cultural and linguistic groups.

3. Services shall be appropriate for:

a. age;

b. development; and

c. education.

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

E. Evidence-based practices require prior approval and fidelity reviews on an ongoing basis as determined necessary by department.

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

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

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§6303. Assessments

A. For mental health rehabilitation services, each enrollee shall be assessed and have a plan of care (POC) developed.

B. Assessments shall be performed by a licensed mental health practitioner (LMHP).

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

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

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§6305. Plan of Care

A. Each enrollee who receives adult mental health rehabilitation services shall have a POC developed based upon the assessment.

B. The individualized POC shall be developed according to the criteria established by the department and in accordance with the provisions of this Rule, the provider manual and other notices or directives issued by the department.

1. The POC is reviewed at least every 365 days and as needed when there is significant change in the individual's circumstances.

C. The plan of care shall be developed by a case manager who acts as an advocate for the individual and is a source of information for the individual and the team.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:359 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 42:60 (January 2016).

§6307. Covered Services

A. The following mental health services shall be reimbursed under the Medicaid Program:

1. therapeutic services, including diagnosis and treatment delivered by LMHPs;
2. rehabilitation services, including community psychiatric support and treatment (CPST) and psychosocial rehabilitation; and
3. crisis intervention services.

B. Service Exclusions. The following shall be excluded from Medicaid 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 tasks oriented and not directly related to the treatment of the recipient's needs; and
3. 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.

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HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:359 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 42:61 (January 2016).

Chapter 65. Provider Participation

§6501. Provider Responsibilities

A. Each provider of adult mental health services shall enter into a contract with one or more of the managed care organizations in order to receive reimbursement for Medicaid covered services.

B. All services shall be delivered in accordance with federal and state laws and regulations, the provisions of this Rule, the provider manual, and other notices or directives issued by the department. The provider shall create and maintain documents to substantiate that all requirements are met.

C. Providers of adult mental health services shall ensure that all services are authorized and any services that exceed established limitations beyond the initial authorization are approved for re-authorization prior to service delivery.

D. Anyone providing adult mental health services must be certified by the department, or its designee, in addition to operating within their scope of practice license.

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

1. a copy of the plan of care and treatment plan;
2. the name of the individual;
3. the dates of service;
4. the nature, content and units of services provided;
5. the progress made toward functional improvement; and
6. the goals of the plan of care and/or treatment plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:360 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:378 (February 2015), LR 42:61 (January 2016).