Subpart 7. Adult Mental Health Services

Chapter 61. General Provisions

§6101. Introduction

A. The Medicaid Program hereby adopts provisions to provide coverage under the Medicaid State Plan for behavioral health services rendered to adults with behavioral health disorders. These services shall be administered under the authority of the Department of Health and Hospitals, Office of Behavioral Health in collaboration with a statewide management organization (SMO) which shall be responsible for the necessary operational and administrative functions to ensure adequate service coordination and delivery.

B. The behavioral health services rendered to adults shall be necessary to reduce the disability resulting from behavioral health illness and to restore the individual to his/her best possible functioning level in the community.

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).

§6103. Recipient Qualifications

A. Individuals over the age of 18, and not otherwise eligible for Medicaid, who meet Medicaid eligibility and clinical criteria established in §6103.B, shall qualify to receive adult behavioral health services.

B. Qualifying individuals who meet one of the following criteria shall be eligible to receive adult behavioral health services.

1. Person with Acute Stabilization Needs

a. The person 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-CM)*, or subsequent revisions of these documents.

b. The person is experiencing at least "moderate" levels of risk to self or others as evidenced by at least a score of 3 and no more than a score of 4 on the Level-of-Care Utilization System (LOCUS) Risk of Harm subscale and/or serious or severe levels of functional impairment as evidenced by at least a score of 4 on the LOCUS Functional Status subscale. This rating is made based on current manifestation and not past history.

2. Person with Major Mental Disorder (MMD)

a. The person has at least one diagnosable mental disorder which is commonly associated with higher levels of impairment. These diagnoses may include:

i. schizophrenia spectrum and other psychotic disorders;

ii. bipolar and related disorders; or

iii. depressive disorders.

b. The person experiences at least moderate levels of need as indicated by at least a composite LOCUS total score of 14 to 16, indicative of a low intensity community-based services level-of-care.

c. A person with a primary diagnosis of a substance use disorder without an additional co-occurring qualifying mental health diagnosis shall not meet the criteria for a major mental disorder diagnosis.

3. Persons with Serious Mental Illness (SMI)

a. The person currently has, or at any time during the past year, had a diagnosable qualifying mental health diagnosis of sufficient duration to meet the diagnostic criteria specified within the DSM-V or the ICD-10-CM, or subsequent revisions of these documents.

b. The person is experiencing moderate levels of need as indicated by at least a composite LOCUS total score of 17 to 19, indicative of at least a high intensity community-based services level-of-care.

c. A person with a primary diagnosis of a substance use disorder without an additional co-occurring qualifying mental health diagnosis shall not meet the criteria for a SMI diagnosis.

4. An adult who has previously met the criteria stated in §6103.B.1-3 and needs subsequent medically necessary services for stabilization and maintenance.

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).

Chapter 63. Services

§6301. General Provisions

A. All behavioral health services must be medically necessary. 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. Services shall be appropriate for:

1. age;

2. development;

3. education; and

4. culture.

D. Anyone providing behavioral health services must be certified by the department, or its designee, in addition to operating 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 site-based facility, in the community, or in the individual's place of residence as outlined in the plan of care.

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 41:378 (February 2015).

§6303. Assessments

A. Each recipient shall undergo an independent assessment prior to receiving behavioral health services. The individual performing the assessment, eligibility, and plan of care shall meet the independent assessment conflict free criteria established by the department.

B. All assessments shall be based upon department designated assessment criteria and in accordance with the provisions of this Rule, the provider manual and other notices or directives issued by the department.

C. The assessments shall be conducted by a case manager who is a physician or licensed mental health

practitioner (LMHP) (in consultation with a psychiatrist who must complete portions of the assessment) who is trained to administer the evaluation and operating within their scope of license, and who is annually recertified.

D. The evaluation and re-evaluation must be finalized through the SMO using the universal needs assessment criteria and qualified SMO personnel. Needs-based eligibility evaluations are conducted at least every 12 months.

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 41:378 (February 2015).

§6305. Plan of Care

A. Each individual who receives adult behavioral health services shall have a plan of care (POC) developed based upon the independent assessment.

B. The individualized plan of care 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 12 months 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. The case manager shall be a physician or an LMHP.

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).

§6307. Covered Services

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

1. therapeutic services, including diagnosis and treatment;

2. rehabilitation services, including community psychiatric support and treatment (CPST) and psychosocial rehabilitation; and

3. crisis intervention services.

B. Service Limitations

1. Psychosocial rehabilitation is limited to 750 hours of group services per calendar year. Hours in excess of 750 may be authorized when deemed medically necessary.

2. Emergent crisis intervention services are limited to six hours per episode. Ongoing crisis intervention services are limited to 66 hours per episode.

C. Service Exclusions. The following services 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;

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 substance abuse services; and

4. services rendered in an institute for mental disease.

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).

Chapter 65. Provider Participation

§6501. Provider Responsibilities

A. Each provider of behavioral health services shall enter into a contract with the statewide management organization 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.

C. Providers of behavioral 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 behavioral health services must be certified by the department, or its designee, in addition to operating within their scope of practice license. To be certified or recertified, providers shall meet the provisions of this Rule, the provider manual and the appropriate statutes. The provider shall create and maintain documents to substantiate that all requirements are met.

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

1. a copy of the 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 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).

Chapter 67. Reimbursement

§6701. Reimbursement Methodology

A. The department, or its fiscal intermediary, shall make monthly capitation payments to the SMO. Payments shall be developed and based upon the fee-for-service reimbursement methodology currently established for the covered services.

B. The capitation rates paid to the SMO shall be actuarially sound rates and the SMO will determine the rates paid to its contracted providers.

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).