Chapter 23. Services

§2301. General Provisions

A. All specialized behavioral health services must be medically necessary. The medical necessity for services shall be determined by a licensed mental health practitioner (LMHP) or physician who is acting within the scope of his/her professional license and applicable state law.

B. Services provided to children and youth must include communication and coordination with the family and/or legal guardian and custodial agency for children in state custody. Coordination with other child-serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the child's medical record.

1. The agency or individual who has the decision making authority for a child or youth in state custody must request and approve the provision of services to the recipient.

C. Children who are in need of specialized behavioral health services shall be served within the context of the family and not as an isolated unit.

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 children and youth of diverse racial, ethnic, religious, sexual, and gender identities and other cultural and linguistic groups.

3. Services shall also be appropriate for:

a. age;

b. development; and

c. education.

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

E. 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 38:364 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2358 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1892 (October 2018).

§2303. Covered Services

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

1. therapeutic services delivered by licensed mental health professionals (LMHP), including diagnosis and treatment;

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

3. crisis intervention services; and

4. crisis stabilization services.

B. 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 services;

4. services rendered in an institute for mental disease other than a psychiatric residential treatment facility (PRTF) or an inpatient psychiatric hospital; and

5. the cost of room and board associated with crisis stabilization.

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 38:364 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2359 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1892 (October 2018).

Subpart 7. Adult Mental Health Services

Chapter 61. General Provisions

§6103. Recipient Qualifications

A. Individuals, 21 years of age and older, who meet Medicaid eligibility, shall qualify to receive adult mental health services referenced in LAC 50:XXXIII.6307 if medically necessary in accordance with LAC 50:I.1101, if the recipient presents with mental health symptoms that are consistent with a diagnosable mental disorder, and the services are therapeutically appropriate and most beneficial to the recipient.

B. Additional Recipient Eligibility Criteria for Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR)

1. Members must meet the Substance Abuse and Mental Health Services Administration (SAMHSA) definition of, serious mental illness (SMI). In addition to having a diagnosable mental disorder, the condition must

substantially interfere with, or limit, one or more major life activities, such as:

a. basic daily living (for example, eating or dressing);

b. instrumental living (for example, taking prescribed medications or getting around the community); or

c. participating in a family, school, or workplace.

2. A member must have a rating of three or greater on the functional status domain on the level of care utilization system (LOCUS).

3. Recipients receiving CPST and/or PSR shall have at least a level of care score of three on the LOCUS.

4. An adult with longstanding deficits who does not experience any acute changes in their status and has previously met the criteria stated in LAC 50:XXXIII.6103.B.2.-3, but who now meets a level of care score of two or lower, 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.

C. An adult with a diagnosis of a substance use disorder or intellectual and developmental disability without an additional co-occurring qualifying mental health diagnosis shall not meet the criteria for adult 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), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1014 (June 2018), LR 46:794 (June 2020), repromulgated LR 46:951 (July 2020).

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 must be authorized.

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 treatment plan. 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.

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), LR 42:60 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1014 (June 2018), repromulgated LR 46:952 (July 2020).

§6303. Assessments

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

B. Assessments for community psychiatric support and treatment (CPST) and psychosocial rehabilitation (PSR) must be performed at least once every 365 days or any time there is 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.

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), LR 42:60 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1014 (June 2018), amended LR 46:795 (June 2020), repromulgated LR 46:952 (July 2020).

§6305. Treatment Plan

A. Each enrollee who receives community psychiatric support and treatment (CPST) and psychosocial rehabilitation (PSR) services shall have a treatment plan developed based upon the assessment.

B. The individualized treatment plan 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 treatment plan shall be reviewed at least once every 180 days or when there is a significant change in the individual's circumstances.

C. The treatment plan shall be developed by the licensed mental health practitioner (LMHP) or physician in collaboration with direct care staff, the recipient, family and natural supports.

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), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1014 (June 2018), LR 46:795 (June 2020), repromulgated LR 46:951 (July 2020).

§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 licensed mental health practitioners (LMHPs) and physicians;

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

3. crisis intervention; and

4. crisis stabilization.

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.

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 42:61 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1015 (June 2018), LR 46:795 (June 2020), repromulgated LR 46:952 (July 2020), amended LR 46:1680 (December 2020), LR 48:1098 (April 2022).

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 (MCOs) in order to receive reimbursement for Medicaid covered services.

B. Providers shall deliver all services in accordance their license and scope of practice, 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.

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), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1015 (June 2018), LR 46:795 (June 2020), repromulgated LR 46:952 (July 2020).