

## **OVERVIEW**

The Mental Health Rehabilitation Program is administered by the Department of Health and Hospitals through a partnership of the Bureau of Health Services Financing (Bureau/BHSF), the fiscal intermediary, and the network of certified and enrolled providers.

The Bureau is the Louisiana Medicaid Program. The Medicaid Behavioral Health Section develops program rules, regulations, policies, and procedures for the operation of the program, as well as manages the operation of the program through prior authorizing services, certifying new providers, recertifying enrolled providers, monitoring providers, and training activities. It provides funding for the reimbursement of prior authorized services to certified and enrolled providers. Contact information:

BHSF/Behavioral Health/MHR Program  
628 North 4<sup>th</sup> Street  
Baton Rouge, LA 70802  
Voice: (225) 342-1203 Fax: (225) 389-8134

UNISYS is the fiscal intermediary that processes billing claims, assists providers with billing problems, and completes the enrollment of new providers. Contact information:

UNISYS Provider Enrollment and Provider Relations  
Post Office Box 80159  
Baton Rouge, LA 70898-0159

Provider Enrollment Unit:  
Voice: (225) 216-6370

Provider Relations:  
Voice: (225) 924-5040 or 1-800-473-2783

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Mental Health Rehabilitation (MHR) services for adults with serious mental illness and children with emotional/behavioral disorders are outpatient services which are medically necessary to reduce the disability resulting from mental illness and assist in the recovery and resiliency of the recipient. These services are home and community-based and are provided on an as needed basis to assist recipients in coping with the symptoms of their illness. The intent of MHR services is to minimize the disabling effects on the individual's capacity for independent living and to prevent or limit the periods of inpatient treatment. Providers offer prior authorized services to adults with mental illness and youth with an emotional/behavioral disorder who meet medical necessity criteria for services.

This is an optional Medicaid service authorized under Section 440.130 of the 42 Code of Federal Regulations. All services must be delivered in accordance with federal and state laws, rules and regulations, this provider manual chapter and any other notices or directives issued by the Bureau. These services must be delivered by practitioners operating within the scope of their license as required by the respective Louisiana Practice Acts. It is the responsibility of each provider to be knowledgeable regarding the policies and procedures governing MHR services and to be aware of revisions issued by the Bureau.

The provider may only serve recipients who reside in the provider's designated service area and are prior authorized. To obtain a list of designated service areas visit the MHR website, [www.mhrsla.org](http://www.mhrsla.org). Reimbursement will not be paid for a duplicated service or a service provided without prior authorization. The provider is required to focus on a recipient's Individual Service/Recovery Plan (ISRP) and his/her environment to reduce dependency on services where the least amount of services is required in the least restrictive environment.

MHR services are expected to achieve the following outcomes:

- Assist recipients in the stabilization of acute symptoms of mental illness;
- Assist recipients in coping with the chronic symptoms of their mental illness;
- Minimize the aspects of mental illness that make it difficult for a recipient to live independently;
- Reduce or prevent psychiatric hospitalizations; and
- For children, minimize the amount of time spent in out-of-home placement and disruptions in school.

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**MHR Program Services Package****Covered Services**

Listed below are the two categories of MHR services that are currently covered by Louisiana Medicaid. All providers who participate in the MHR program must offer mandatory services. Optional services are additional services that may be offered, but require special provider certification.

**Mandatory Services**

- Assessment/Reassessment and Service Planning,
- Community Support,
- Individual Intervention,
- Parent/Family Intervention (Counseling),
- Group Counseling,
- Psychosocial Skills Training-Group (Youth), and
- Medication Management.

**Optional Services**

- Parent/Family Intervention (Intensive), and
- Psychosocial Skills Training-Group (Adult).

The following activities **are not** MHR services and **are not reimbursable**:

- Tutoring activities,
- Teaching job related skills (management of symptoms and appropriate work habits may be taught),
- Vocational rehabilitation,
- Transportation,
- Staff training ,
- Preparation for group activities,
- Attempts to reach the recipient by telephone to schedule, confirm, or cancel appointments,
- Staff supervision ,
- Completion of paper work (including but not limited to service logs, assessments, ISRPs) when the recipient and/or their significant others are not present. **NOTE:** Requiring recipients to be present only for documentation purposes is not reimbursable.

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- Team meetings and collaboration exclusively with staff employed or contracted by the provider where the recipient and/or their significant others are not present,
- Recreational outings,
- Observation of the recipient,
- Staff research on behalf of the recipient, and

**NOTE: This list is not all-inclusive.**

### **Screening for Medical Necessity**

When a recipient requests services, an initial screening must be completed to determine if the recipient potentially meets the medical necessity criteria for services. All recipients must meet the medical necessity criteria for diagnosis, disability, duration and level of care in order to receive MHR services. If it is determined that the recipient potentially meets the criteria for services, an initial assessment shall be completed and fully documented in the recipient's record no later than thirty (30) days after the request for services is received.

Recipient data must be entered into MHRISIS. Providers shall also rate recipients on the LOCUS/CALOCUS and enter the score into MHRISIS at the end of each authorization period (except the interim authorization), with a request for revision and upon request of the Bureau. The case record must contain documentation to support the rating including but not limited to, the initial assessment, reassessment and other supportive documents. The LOCUS/CALOCUS must be conducted face-to-face by an approved clinical evaluator (ACE).

If it is determined at the initial screening or assessment that a recipient does not meet the medical necessity criteria for services, the provider shall refer the recipient to his/her primary care physician, the nearest community mental health clinic, or other appropriate services with copies of all available medical and social information. Documentation of all referrals must be entered into MHRISIS.

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**Medical Necessity Criteria****Adult Criteria for Services**

In order to qualify for services, Medicaid recipients who are age eighteen (18) or older must meet all of the following criteria in the areas of diagnosis, disability and duration of disability.

- **Diagnosis.** The recipient must currently have or, at any time during the past year, had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet the diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) or the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM); or subsequent revisions of these documents. The diagnostic criteria specified under DSM-IV-TR “V” codes, as well as those for substance abuse disorders and developmental disorders are excluded unless these disorders co-occur with another diagnosable serious mental illness.

*and*

- **Disability.** In order to meet the criteria for disability, the recipient must exhibit emotional, cognitive or behavioral functioning, which is impaired, as a result of mental illness. This impairment must substantially interfere with role, occupational and social functioning as indicated by a score within levels four (4) or five (5) on the Level of Care Utilization System (LOCUS) and can be verified by the Bureau.

*and*

- **Duration.** The recipient must have a documented history of severe psychiatric disability which is expected to persist for at least a year and requires intensive mental health services, as indicated by one of the following:
  - Psychiatric hospitalizations of at least (6) six months duration in the last five (5) years (cumulative total); or
  - Two (2) or more hospitalizations for mental disorders in the last twelve (12)-month period; or
  - Structured psychiatric residential care, other than hospitalization, for a duration of at least six (6) months in the last five (5) years; or
  - A severe psychiatric disability of at least six (6) months duration in the past year.

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Acceptable documentation includes, but is not limited to, records from a school, a court, a psychiatric hospital, a community mental health clinic (CMHC), an outpatient mental health center, a physician, the Office of Juvenile Justice Development (OJJ) or the Office of Community Services (OCS). Documentation must be generated by an authorized professional of the entity.

**NOTE:** Recipients who are between the ages of eighteen (18) and twenty (21) and who have been determined not to meet the adult medical necessity criteria for services, initial or continued care, shall be reassessed by the Bureau or its designee using the children/youth medical necessity criteria for services.

**Children/Youth Criteria for Services**

In order to qualify for services, Medicaid recipients who are age seventeen (17) or younger must meet all of the following criteria:

- **Diagnosis.** The recipient must currently have or, at any time during the past year, had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet the diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) or the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM), or subsequent revisions of these documents. The diagnostic criteria specified under DSM-IV-TR “V” codes, as well as those for substance abuse disorders and developmental disorders are excluded unless these disorders co-occur with another diagnosable serious mental illness.

*and*

- **Disability.** In order to meet the criteria for disability, the recipient must exhibit emotional, cognitive or behavioral functioning, which is impaired, as a result of mental illness. This impairment must substantially interfere with role, educational, and social functioning as indicated by a score within levels four (4) or five (5) on the Child and Adolescent Level of Care Utilization System (CALOCUS) and can be verified by the Bureau.

**NOTE:** Youth returning to community living from structured residential settings or group homes under the authority of the OCS or the OJJ may be considered to meet the disability criteria with a level of three (3) on the LOCUS or CALOCUS.

*and*

- **Duration.** The recipient must have a documented history of severe psychiatric disability that is expected to persist for at least six (6) months and requires intensive mental health services, as indicated by at least one (1) of the following:

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- Past psychiatric hospitalization(s);
- Past supported residential care for emotional/behavioral disorder;
- Past structured day program treatment for emotional/behavioral disorder; or
- An impairment or pattern of inappropriate behaviors that has persisted for at least three (3) months and is expected to persist for at least six (6) months.

Acceptable documentation includes, but is not limited to, records from a school, court, psychiatric hospital, CMHC, outpatient mental health center, and OJJ or OCS. Documentation must be generated by an authorized professional of the entity.

**Exclusionary Criteria**

Services are not considered to be appropriate for recipients whose diagnosis is mental retardation, developmental disability or substance abuse unless they have a co-occurring diagnosis of severe mental illness or emotional/behavioral disorder as specified within DSM-IV-TR or ICD-9-CM, or subsequent revisions of these documents.

**Discharge Criteria**

Discharge planning must be initiated and documented for all recipients at the time of their admission to the program. The written discharge plan must include a plan for the arrangement of services required to transition the recipient to a lower level of care within the community. Discharge shall be initiated if at least one (1) of the following situations occurs:

- The goals and objectives on a recipient's ISRP have been substantially met;
- The recipient meets criteria for higher level of treatment, care, or services such as a Medicare funded day program;
- The recipient meets criteria for higher level of treatment, care or services requiring admission to a twenty four (24) hour care facility for thirty (30) days or more;
- The recipient, family, guardian, and/or custodian are not engaging in treatment or not following program rules and regulation, despite attempts to address barriers to treatment;
- Consent for treatment has been withdrawn; or
- Supportive systems that allow the recipient to be maintained in a less restrictive treatment environment have been arranged such as a CMHC or other outpatient mental health program.

If any one of these situation occur, the provider shall implement the recipient's written discharge plan, which includes a plan for the arrangement of services required to transition the recipient.