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**CHAPTER 31: MENTAL HEALTH REHABILITATION**

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## **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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**NOTE:** The provider must ensure and document that a recipient who chooses a non-MHR physician who is not a psychiatrist receives a face-to-face interview, review of Medical History Questionnaire section, review of the ISRP and review of the e-CDI screen performed by a qualified psychiatrist.

The licensed mental health professional (LMHP) shall:

- Direct the gathering of the assessment data.
- Conduct a face-to-face interview with the recipient. The recipient's family/significant other(s) should also be interviewed when possible if approved by the recipient. For a recipient who is a minor, an interview with the custodial parent(s) is mandatory.
- Score LOCUS/CALOCUS if he/she has been designated by Medicaid Behavioral Health Section as an Approved Clinical Evaluator (ACE).
- Develop the Integrated Summary as part of the initial assessment.
- Conduct a mental status exam as part of the initial assessment and reassessment. LMHP staff must have documented experience with conducting mental status exams.
- Determine the presence of a DSM IV diagnosis, Axes I-V as part of the initial assessment and reassessment. The LMHP must have documented experience with determining psychiatric diagnosis.
- Develop, sign and date the initial assessment and the reassessment forms.
- Obtain information about the recipient that may minimize the need for use of restraint or seclusion.

**NOTE:** An advanced practice registered nurse (APRN), clinical nurse specialist (CNS) or a nurse practitioner (NP) may not sign the initial assessment without the signature of the treating psychiatrist.

The initial assessment and reassessment shall be billed by the LMHP coordinating the assessment activities. Although they may not bill for the service, other qualified staff such as a mental health professional (MHP) or a mental health specialist (MHS) may participate in gathering data. The LMHP must complete a service log on the date the assessment is completed and enter into MHRISIS to be reimbursed.

**NOTE:** Staff must not bill community support while gathering and reporting reassessment information.

**Service Specific Documentation Requirements**

Service logs must be completed for all contacts during an assessment and filed in the recipient's record, though not all logs are entered into MHRISIS. Providers shall follow current MHRISIS policies regarding entering data.

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**Staffing Requirements**

The service must be provided under the supervision of an LMHP with a minimum of two (2) years experience providing services to children, youths and their families. The services must be provided by one of the following:

- An LMHP,
- An MHP, or
- An MHS.

Group size may not exceed eight (8) recipients for any single skill building activity.

**Service Authorization Periods**

The training material must be organized into a specific number of sessions, not to exceed twenty (20) sessions, (services that meet the definition of medication management should be provided by staff credentialed to offer that service) for each topic area (curriculum). A recipient would normally participate for six (6) to eighteen (18) months.

- Interim – None
- Initial – ninety (90) days
- Reassessment – up to ninety (90) days

**Optional Services**

Optional services may only be offered by providers that have been certified by Medicaid Behavioral Health Section to provide this service. Refer to Section 31.3 for the optional services certification process.

**Parent/Family Intervention (Intensive) (Youth Only)****Service Definition**

Parent/Family Intervention (Intensive) (PFII) is a structured service involving the recipient and one (1) or more of his/her family members. It is an intensive family preservation intervention intended to stabilize the living arrangement, promote reunification, or prevent utilization of out of home therapeutic placement (i.e., psychiatric hospitalization, therapeutic foster care) for the recipient. This service focuses on the family; and is delivered to children and youths primarily in their homes. Therefore, PFII is not appropriate for recipients whose families refuse to participate or to allow services in the home. This service utilizes specific interventions, which must be documented in the recipient's ISRP. Evidenced based strategies should be used when applicable and tailored to address the recipient's and family's needs

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- Identification and management of symptoms of mental illness.
- Compliance with physician's medication orders.
- Education in mental health/mental illness:
  - Management of symptoms of mental illness to minimize the negative effects of psychiatric symptoms which interfere with the recipient's daily living, financial management, personal development, and community integration (services that meet the definition of medication management should be provided by staff credentialed to offer that service); and
  - Developing skills necessary for the recipient to comply with prescribed medications.
- Work readiness activities as part of a clubhouse model (excepting skills related to a specific vocation, trade, or practice):
  - Work related social and communication skills;
  - Work related personal hygiene and attire;
  - Work related time management; and
  - Other related skills preparing the recipient to be employable.

This service must have an ongoing process to ensure that recipients participate in the development and periodic revision of program curricula. The curriculum must be designed to improve or maintain the recipient's ability to function in normal social roles and ensure that the methods and materials utilized are age and developmentally appropriate and culturally relevant.

It must utilize one (1) or more of the following three (3) Medicaid Behavioral Health Section designated psychosocial rehabilitation program models or combine elements from each in a clearly delineated program approach:

- Boston Psychiatric Rehabilitation Model,
- Clubhouse Model, or
- Social Skills Training Model.

Training material must include activities that will allow each recipient to practice the skill(s) taught during the group session and in natural settings. This will allow the recipient to further develop and integrate the skill taught. The training material must be organized into a specific number of sessions for each topic area (curriculum). If a recipient completes a curriculum but needs additional training, community support should be used during or after the group sessions as a more individualized method of training.

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If a provider does not offer PSR services, the recipient must be given a list of PSR providers from which to choose a provider. The name of the provider of choice is placed on the ISRP along with other requested services. The authorization staff will authorize all medically necessary services on the ISRP, by provider and send the prior authorization decision for each service to the appropriate provider.

It is the responsibility of the community support worker to ensure services are coordinated between the two (2) providers. Providers should develop ongoing working relationships with PSR providers in their area that may include the development of a memorandum of understanding.

**Place of Service**

Services must be provided in a location that ensures confidentiality. Locations including, but not limited to retail outlets, libraries, sporting events, etc. do not meet guidelines for confidentiality and may not be used for groups. Individual skills training could be provided in such locations, if related to the ISRP and conducted in a manner as to promote normalization and prevent stigmatization.

This service shall not be provided at a site that serves as a group living environment, such as a board and care facility, group home or apartment building that serves as a residence for more than one MHR recipient. No collateral contact or other non face-to-face service is billable under this service description. A group recreational outing is not a billable service.

**Staffing Requirements**

All staff providing direct services must have documented orientation to the psychosocial rehabilitation model used.

This service shall be furnished under the supervision of an LMHP who is on site a minimum of 50 fifty percent (50%) of the service operating hours. The supervising LMHP shall be a Certified Psychosocial Rehabilitation Practitioner (CPRP) as designated by the Commission for Psychiatric Rehabilitation Certification through United States Psychiatric Rehabilitation Association (USPRA). If the LMHP is not a CPRP, he/she must be eligible for certification with a written plan for achieving certification. This must be accomplished within twelve (12) months of the provider's certification or within twelve (12) months of being hired.

Providers must submit information requested by the Bureau regarding the certification status of each LMHP supervisor. Failure to do so may result in administrative sanctions or decertifying the program. If an LMHP does not pass the certification exam, a written corrective action plan must be submitted to the Medicaid Behavioral Health Section within thirty (30) calendar days of the notification.

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The provider requesting authorization for a new recipient will follow phases one (1) through three (3). Providers requesting a reauthorization will follow phase four (4). There are seven (7) additional service access and authorization activities detailed below which require providers to submit information to the SAA unit. Providers must submit the required documentation with each request.

To obtain MHR forms and denial codes referenced below, visit the MHR website at [www.mhrsla.org](http://www.mhrsla.org). If you need assistance, contact a network services representative at (225) 342-1203.

## **Service Access and Authorization Process**

### **Phase One (1): Screening for MHR Eligibility**

When a recipient requests services, an initial screening must be completed to determine whether the recipient meets the medical necessity criteria for services. Recipient data must be entered into MHRISIS.

Based on the results of the screening, the LMHP shall make one (1) of two (2) determinations:

1. The recipient does not meet medical necessity criteria and is referred to appropriate community resources. The referral must be entered in MHRISIS before the record is closed.
2. The recipient seems to meet eligibility criteria and will move onto phase two (2).

### **Phase Two (2): Determining Eligibility and Developing an Interim ISRP**

If the recipient seems to meet medical necessity criteria, the provider continues the eligibility process, which may include, but is not limited to, the following:

1. Obtaining a Freedom of Choice form signed by the recipient ,
2. Opening the case in MHRISIS and completing a Client Data Form
3. Conducting the Initial Assessment (including rating the LOCUS or CALOCUS) ,
4. Developing an interim ISRP, which must address the recipient's immediate needs,
5. Review of the e-CDI data, if available. The treating psychiatrist and LMHP must review, sign, and date the printout,
6. Entering the LOCUS or CALOCUS rating into MHRISIS, and
7. Sending a data file.

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Initial assessment data is collected and documented on the Initial Assessment form and must be completed within thirty (30) calendar days following the eligibility screening. Extensions beyond the thirty (30) day assessment period may be granted on a case-by-case basis, under exceptional circumstances at the discretion of the Medicaid Behavioral Health Section. Requests for extensions should be thoroughly documented and directly related to the reason for the delay. (Example: a fifteen (15) day extension is requested because the recipient was hospitalized for fifteen (15) days.).

To establish eligibility for the program, the following must be met to receive an interim authorization:

- Recipient/family agrees to receive services from the provider as indicated by a signature on the Freedom of Choice form;
- Recipient meets the medical necessity criteria;
- Recipient has a LOCUS or CALOCUS level of four (4) or above (level three (3) or above if returning to community living from structured residential settings under OCS or OJJ authority);
- Documentation indicates a thorough and accurate assessment which supports the diagnosis and LOCUS or CALOCUS level;
- Recipient has agreed to participate in the development of the interim ISRP as indicated by a signature on the ISRP (all children six (6) and older must sign plan);
- The crisis plan addresses areas in which the recipient is at risk of harm;
- The interim ISRP reflects the most urgent needs of the recipient;
- The request packet includes all of the required documentation and signatures;
- All identifying information such as Social Security number, address, Medicaid number are present; and
- A record in MHRSIS must be opened and a data file submitted before an authorization request is submitted to SAA.

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

**Approval for Eligibility**

If the request meets the established criteria the assessment is approved back to the date it was completed and signed by the LMHP, unless the provider fails to submit it within thirty (30) calendar days of the initial screening. The interim authorization begins on the date the assessment is completed and signed, and extends thirty (30) days forward from the date PA issues an approval. The interim authorization ends when the initial ISRP is approved or when the interim authorization period ends. The approval notice is sent electronically through MHRSIS to the provider. Recipients are mailed approval letters.

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**PROVIDER CERTIFICATION AND RECERTIFICATION**

When applying for certification and enrollment, prospective providers must follow the process described below.

The provider shall have a separate Medicaid provider number for each location where business is routinely conducted and services are provided. This does not include those sites or locations that meet the definition of an off-site service delivery location. Each site must be accredited.

**NOTE:** The provider must maintain a current policies and procedures manual as described in Section 31.4 of this manual chapter. This manual must be made available to the Bureau upon request.

**Initial Certification and Enrollment**

An initial provider certification and enrollment is required for applicants requesting:

- Certification and enrollment as an MHR provider
- Change in ownership

The Medicaid Behavioral Health Section and the fiscal intermediary conduct the initial provider certification and enrollment reviews. The Medicaid Behavioral Health Section reviews the MHR certification application to ensure the applicant meets MHR certification criteria. The Medicaid Behavioral Health Section review may include at least one (1) on-site review. If the application and site review meet certification requirements, the LA Medicaid enrollment applications are forwarded to the provider enrollment unit at the fiscal intermediary for the enrollment review.

The fiscal intermediary reviews the completed LA Medicaid applications. If the applicant meets the Medicaid enrollment criteria, a provider number will be issued. Failure to meet certification and enrollment criteria or failure to follow the standard response timelines listed below may result in a certification and enrollment denial and possible exclusion from the MHR program.

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**Initial Certification and Enrollment Applications**

To obtain one (1) or more of the certification and enrollment applications, or if you have any questions about the initial certification and enrollment process, you may contact a network services representative by calling (225) 342-1203 or post your question on the MHR website, [www.mhrsla.org](http://www.mhrsla.org).

An applicant who elects to enroll with the department to provide MHR services shall apply to the Bureau for certification. The applicant shall create and maintain documents to substantiate that the applicant meets all prerequisites in order to enroll.

An **applicant shall submit the following documents for certification:**

- MHR initial certification application;
- Medicaid Basic Enrollment Packet for Entities/Businesses;
- Enrollment packet for the Louisiana Medical Assistance Program-Mental Health Rehabilitation;
- Enrollment packet for the Louisiana Medical Assistance Program-Physician, individual or group, if applicable.
- If the physician is already enrolled as a Medicaid provider, the Group Linkage/Unlinkage form must be completed.

The MHR Initial Certification Application includes required attachments, which are listed below:

- Proof of a request for accreditation and a copy of the completed application with a national accrediting body approved by the bureau and proof of payment to the accrediting body. Proof of full accreditation is required within nine (9) months of issuance of a Medicaid provider enrollment number;
- Proof of the establishment and maintenance of a line of credit from a federally insured, licensed lending institution in an amount equal to three (3) months of current operating expenses as proof of adequate finances. A budget showing actual or projected monthly expenses shall be attached. It is the MHR provider's responsibility to notify the bureau in the event that the financial institution cancels or reduces the upper credit limit.

Nonprofit agencies that have operated for five (5) years or more and have an un-qualified audit report for the most recent fiscal year prepared by a licensed certified public accountant, which reflects financial soundness of the nonprofit provider, are not required to meet this standard.

Government entities or organizations are exempt from this requirement.

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- Proof of the establishment and maintenance of a general liability and a professional liability insurance policy with at least \$1,000,000 coverage under each policy. Providers with more than one certified and enrolled site must have a separate policy for each location or each location must be identified on the provider’s policy. The certificates of insurance for these policies shall be in the name of the provider and the certificate holder shall be the Department of Health and Hospitals with the following mailing address:

For USPS mail delivery:

For hand delivery or delivery via a parcel service:

Medicaid Behavioral Health Section  
P.O. Box 91030  
Baton Rouge, LA 70821-9030

Medicaid Behavioral Health Section  
Bienville Bldg., 7<sup>th</sup> Floor  
628 North 4<sup>th</sup> Street  
Baton Rouge, LA 70802

The provider shall notify the Bureau when coverage is terminated for any reason. Coverage shall be maintained continuously throughout the time services are provided and thereafter for a period of one year. Government entities or organizations are exempt from this requirement.

- Corporations must provide current proof of business registration with the Secretary of State.
- Proof of an inspection and approval of the Office of Public Health (OPH), Sanitation Department for on-site and off-site locations.
- Proof of current inspection and approval by the Office of State Fire Marshal for on-site and off-site locations.

The provider must meet the minimum clinical competence criteria. To meet this requirement, each organization must have documented clinical experience providing mental health services to the population served by that organization. As such, each organization must have a combined three (3) years (in one(1) year increments), experience providing mental health services to adults or children/youth who meet the criteria for MHR as described in Section 31.0. If an organization provides services to both youth and adult recipients, then 3 years clinical experience must be demonstrated for each recipient population. Each organization providing Psychosocial Skills Training (Adult) must also establish compliance with MHR CPRP staffing requirements.

The provider may be required to submit documentation such as staff resumes to document compliance with this requirement. The provider shall employ sufficient staff to meet the minimum clinical competency standard.

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**PAGES (11)****Optional Services Certification**

An applicant who elects to offer one (1) or more optional services shall apply to the Bureau. The applicant shall create and maintain documents to substantiate that the provider meets all prerequisites for certification. The certification application is reviewed by the Medicaid Behavioral Health Section to ensure the applicant meets standard criteria for providing the services. The Medicaid Behavioral Health Section review may include at least one on-site visit. A request to provide an optional service may be submitted when an applicant is applying for initial certification and enrollment. If the request is submitted with an initial certification and enrollment request, the optional service application and site review may be conducted at the same time as the initial application and on-site review.

**Optional Services Certification Applications**

An applicant shall submit the following documents for certification:

- MHR Optional Services Certification Application  
Psychosocial Rehabilitation Certification Application  
Parent/Family Intervention Intensive Certification Application;
- Comprehensive implementation plan;

For PSR:

- Proof of current inspection and approval of the site for psychosocial rehabilitation, by the Office of State Fire Marshal;
- Proof of current inspection and approval of the site, by the Office of Public Health; and
- Proof that the supervising LMHP is a Certified Psychosocial Rehabilitation Practitioner (CPRP). If the LMHP is not a CPRP, submit a written plan for achieving certification within twelve (12) months of the provider's certification or within twelve (12) months of being hired.

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**Certification Process**

This process applies to initial certification, enrollment, and certification to provide one (1) or more optional service.

**Provider Application Review****Application and Site Review(s)**

An applicant must mail or hand deliver the completed application (s) with required attachments to the following address:

For USPS mail delivery:

Medicaid Behavioral Health Section  
P.O. Box 91030  
Baton Rouge, LA 70821-9030

For hand delivery or delivery via a parcel service:

Medicaid Behavioral Health Section  
Bienville Bldg., 7<sup>th</sup> Floor  
628 North 4<sup>th</sup> Street  
Baton Rouge, LA 70802

An applicant shall undergo one (1) or more of the following reviews by the Bureau before certification to provide mandatory or optional services to ensure compliance with provider enrollment and operational requirements:

- an application review;
- a first site review; and if necessary
- a second site review.

The bureau may conduct a review of all application documents for compliance with MHR requirements. The certification application must be approved by the Bureau prior to the first site review of the applicant's physical location.

- If the application documentation furnished by the applicant is not acceptable, the applicant will be notified of the deficiencies.
  - The applicant has thirty (30) days from the date of receipt of the notice to correct the document deficiencies. If the applicant fails to resubmit the application or if the application is not approved, certification may be denied.
- Following approval of the application, the applicant will have thirty (30) days to schedule the first site review.
  - If the applicant does not request a site visit within thirty (30) days, certification may be denied.

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**PAGES (11)****Recertification**

The Bureau may conduct a recertification review to ensure continued compliance with all MHR regulations and policies. Certified providers shall apply for recertification annually. The recertification application must be submitted ninety (90) days prior to the expiration of the provider's current certification. The Bureau may conduct a recertification review to ensure continued compliance with all MHR regulations and policies. The completed recertification application and any required attachments must be submitted to:

For USPS mail delivery:

For hand delivery or delivery via a parcel service:

Medicaid Behavioral Health Section  
P.O. Box 91030  
Baton Rouge, LA 70821-9030

Medicaid Behavioral Health Section  
Bienville Bldg., 7<sup>th</sup> Floor  
628 North 4<sup>th</sup> Street  
Baton Rouge, LA 70802

Fax: (225) 342-1972 or (225) 342-1973 or Toll Free at (866) 427-2148

Required recertification application attachments may include but are not limited to the accreditation report, copies of specific policies or procedures, and current staff information. Required documentation may differ among providers based upon individual provider profiles. An on-site review may be conducted to ensure compliance with all rules and requirements (see Section 31.3).

**Failure to Recertify**

If the applicant fails to meet any recertification requirements and recertification is denied,, the provider may be terminated and may not reapply for one year from the date of the notice of termination.

Providers that fail to meet all requirements for recertification will receive a written notice identifying the deficiencies. These deficiencies must be corrected within sixty (60) days of the date of the notice. Failure to resubmit the application within sixty (60) calendar days and/or failure to correct the deficiencies may result in sanction(s), including loss of certification and termination from the program.

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**Accreditation**

Currently enrolled providers shall be accredited by a national accreditation organization for any services for which Medicaid reimbursement will be requested. The Bureau shall only accept accreditation from the national organizations listed below for the purposes of enrolling a provider into the program. New providers must present proof of full accreditation by one of the following national organizations within nine months following the certification date:

- The Council on Accreditation,
- The Commission on Accreditation of Rehabilitation Facilities, or
- The Joint Commission on Accreditation of Health Care Organizations.

All enrolled providers shall maintain accreditation status. Denial, loss of or any negative change in accreditation status must be reported to the Bureau in writing within five (5) working days of receiving the notice from the accrediting organization. The written notification shall include information detailing a copy of the accreditation report and any related correspondence including but not limited to:

- The provider’s denial or loss of accreditation status;
- Any negative change in accreditation status;
- The steps and timeframes, if applicable, the accreditation organization is requiring from the providers to maintain accreditation.

Failure to notify the Bureau of denial, loss of or any negative change in accreditation status may result in sanctions including loss of certification.

Accreditation approval letters and other written notifications from accrediting organization must be sent to:

For USPS mail delivery:

For hand delivery or delivery via a parcel service:

Medicaid Behavioral Health Section  
P.O. Box 91030  
Baton Rouge, LA 70821-9030

Medicaid Behavioral Health Section  
Bienville Bldg., 7<sup>th</sup> Floor  
628 North 4<sup>th</sup> Street  
Baton Rouge, LA 70802

Fax: (225) 342-1972 or (225) 342-1973 or Toll Free at (866) 427-2148

If at any time, a provider loses accreditation, an automatic loss of certification may occur. The applicant may not reapply for one year from the effective date of the termination.

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**PAGES (11)****Changes or Events That Must Be Reported**

Certain changes or events must be reported in writing to Medicaid Behavioral Health Section or fiscal intermediary at the addresses or fax numbers provided below. Since failure to comply with this requirement may result in sanctions against the provider, it is advisable to confirm receipt of the change reported.

**Changes to Report to Fiscal Agent**

A provider must submit a written statement requesting the provider enrollment unit to unlink a psychiatrist when he/she discontinues employment with the provider. The change must be reported to:

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

**Changes to Report to Medicaid Behavioral Health Section**

All changes reported to the Medicaid Behavioral Health Section must be faxed to Network Services at (225) 342-1972 or (225) 342-1973 or Toll Free at (866) 427-2148 or using a Change Report Form. To obtain MHR forms, visit the MHR website, [www.mhrsla.org](http://www.mhrsla.org). If you need assistance, contact a Network Services representative by calling (225) 342-1203.

**Change of Address**

A Change Report Form with the following attachments must be submitted to the Medicaid Behavioral Health Section sixty (60) days prior to the first day of operation in the new location.

**Attachments**

- Proof of an inspection and approval of the Office of Public Health, Sanitation Department
- Proof of current inspection and approval by the Office of State Fire Marshall

**NOTE:** The inspections may not be required if the provider is moving to a different office location within the same building.

The provider must request an on-site review thirty (30) days prior to the first day of operation in the new location. The Bureau may conduct a site review to ensure the location complies with operational requirements. If the new site is approved, the Bureau will notify the fiscal intermediary. Failure to comply with one or more of the requirements listed above may result in sanction(s) against the provider.

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**NOTE:** Establishment of an additional office location is not a change. A new office location requires a new provider certification application to be submitted.

**Off-site Service Delivery Location**

Providers who regularly use the same off-site service delivery location solely for the provision of service delivery must notify the Bureau.

A Change Report Form with the following attachments must be submitted to the Medicaid Behavioral Health Section sixty (60) days prior to the first day of operation in the new location. The Medicaid Behavioral Health Section may conduct a site review.

**Attachments**

- Proof of an inspection and approval of the Office of Public Health Sanitation Department
- Proof of current inspection and approval by the Office of State Fire Marshal

**Change in Contact Information**

Changes in the provider’s telephone number (voice and fax) and provider’s email address (s) on file with the Medicaid Behavioral Health Section must be reported at the time the change is made.

**Change of Population**

Changes in the population served must be reported at the time the change is made. The provider’s policies and procedures must be updated to reflect the change. MHRIS data must be updated must be reflected on the Freedom of Choice Form.

**Changes of Ownership (CHOW)**

A Change Report Form must be submitted to the Medicaid Behavioral Health Section sixty (60) days prior to the change in ownership. The new owner must meet all certification requirements as an MHR provider outlined earlier in this section. The Bureau will conduct a certification review to ensure the new owner complies with all applicable federal and state regulations.

All recipients who are willing to continue receiving services from the new provider must complete a Freedom of choice form.

**NOTE:** Services cannot be provided or billed by the new provider until all certification and Medicaid enrollment requirements have been met.

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**Request to Discontinue Offering One or More Optional Services**

If a provider chooses to discontinue offering an optional service, this change must be reported. Prior to discontinuance, the recipient must complete a new Freedom of Choice form.

**Agency Closures**

If a provider makes the decision to voluntarily close, a Change Report Form must be submitted to the Medicaid Behavioral Health Section thirty (30) days prior to the closure date. Notification shall include the last date services will be provided and the location where recipient and administrative records will be stored.

**Staff**

Changes in the employment of required staff, including LMHP, psychiatrist, and CPRP staff must be reported at the time the change is made. A change includes hiring or firing a required staff member. The provider must update the staff record in MHRIS to reflect the change.

**Accreditation Status**

The provider must submit a Change Report Form to the Medicaid Behavioral Health Section immediately upon notification of an accreditation loss. The provider must attach all documentation (letter or reports) from the accrediting body as described above.

**Insurance Coverage**

The provider must immediately report cancellation of required insurance coverage.

**Hours of Operation**

The provider must report any changes in his/her hours of operation.

**Reportable Events**

- Accredited organizations must report information about significant or critical events including sentinel events, investigations, material litigation, and catastrophes. The provider must submit a Change Report Form to the Medicaid Behavioral Health Section.
- Any other occurrence, which affects compliance with certification requirements.

**CHAPTER 31: MENTAL HEALTH REHABILITATION****SECTION 31.4: PROGRAM OPERATIONS****PAGE (S) 10**

Services may be delivered in off-site service delivery locations that are:

- Publicly available and commonly used by members of the community other than the provider (e.g., libraries, community centers, Young Men's Christian Association (YMCA), church meeting rooms, etc.);
- Used solely for the provision of allowable off-site service delivery;
- Directly related to the recipient's usual environment (e.g., home, place of work, school); or
- Utilized in a non-routine manner (e.g., hospital emergency rooms or any other location in which a crisis intervention service is provided during the course of the crisis).

**NOTE:** Providers who utilize off-site service delivery locations solely for the provision of allowable services must notify the Medicaid Behavioral Health Section regarding this reportable change as outlined in the Provider Certification and Recertification section of this manual (section 31.3). The Medicaid Behavioral Health Section may conduct a site review. Off-site service delivery locations may not house records, maintain staff or be used to conduct regular business.

Every location where services are provided shall be established with the intent to promote growth and development, recipient confidentiality and safety. Service may not be provided in the home (s) of the provider's owner, employees or agents. Group counseling and psychosocial skills training (adult and children/youth) services may not be provided in a recipient's home or place of residence. Services may not be provided in the professional practitioner's private office.

The provider accepts full responsibility to ensure that its office locations meet all applicable federal, state and local licensing requirements. The transferring of license and certifications to new locations is strictly prohibited. It is also the responsibility of the provider to notify the Bureau immediately of any office relocation or change of address and to obtain a new certification and license (if applicable).

Each provider must develop and implement an emergency preparedness plan that includes:

- The measures that will be taken to ensure the safety and security of employees and recipients;
- Provisions to protect business records, including employee and recipient records; and
- A means of communication with the Bureau to report status of the provider post-disaster.

**NOTE:** If the provider must close its offices due to the disaster, the provider may not resume provision of reimbursable services until authorized to do so by the Bureau.

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**CHAPTER 31: MENTAL HEALTH REHABILITATION**

**SECTION 31.6: RECORD KEEPING**

**RECORD KEEPING**

Provider records must be maintained in an organized and standardized format at the enrolled office site. Original records shall not be kept in off-site service delivery locations. The provider must have adequate space, facilities, and supplies to ensure effective record keeping.

**Retention of Records**

The provider must retain administrative, personnel and recipient records for five (5) years from the date of the last payment. However, if the provider is being audited, records must be retained until the audit is complete, even if the five (5) years is exceeded.

In the event records are destroyed or partially destroyed in a disaster, such as a fire, flood or hurricane and rendered unreadable and unusable, such records must be properly disposed of in a manner, which protects recipients' confidentiality. A letter of attestation (refer to Appendix B) must be submitted to:

For USPS mail delivery:

For hand delivery or delivery via a parcel service:

Medicaid Behavioral Health Section  
P.O. Box 91030  
Baton Rouge, LA 70821-9030

Medicaid Behavioral Health Section  
Bienville Bldg., 7<sup>th</sup> Floor  
628 North 4<sup>th</sup> Street  
Baton Rouge, LA 70802

Fax: (225) 342-1972 or (225) 342-1973 or Toll Free at (866) 427-2148

**NOTE:** Upon agency closure, all provider records must be maintained according to applicable laws, regulations and the above record retention requirements. The Bureau must be notified of the location of the records.

**Destruction of Records**

After the required record retention period has expired, records may be destroyed. Confidential records must be incinerated or shredded to protect sensitive information. Non-paper files, such as computer files, require a special means of destruction. Disks or drives can be erased and reused, but care must be taken to ensure all data is removed prior to reuse. Commercially available software programs can be used to ensure all confidential data is removed.

**Confidentiality and Protection of Records**

Administrative and recipient records are the property of the provider. Records must be secured against loss, tampering, destruction or unauthorized use in accordance with Health Insurance Portability and Accountability Act (HIPAA) regulations.

**CHAPTER 31: MENTAL HEALTH REHABILITATION**

**SECTION 31.8: ADMINISTRATIVE SANCTIONS**

- If a provider uses false, fraudulent or misleading advertising;
- Failure to disclose a conviction for a criminal offense by a person who has ownership or controlling interest in the provider agency, or by a person who is an agent or managing employee of the MHR provider; or
- If the facts determined by the department indicate a failure to provide optimum care in accordance with current standards of practice.

**Informal Review**

Any provider receiving a notice of sanction may be provided an opportunity to request an informal review. The request for an informal review must be made in accordance with the instructions in the notice of sanction.

The informal review process is designed to allow the provider to:

- Review the reasons and rationale for the proposed sanction(s);
- Discuss the reasons and findings related to the proposed sanction(s);
- Ask questions and seek clarification; and/or
- Submit additional relevant information.

To arrange an informal review, the request must be made by the provider in writing and within fifteen (15) calendar days (including Saturdays and Sundays) of receipt of original notice of sanction. All such written requests must be sent to:

For USPS mail delivery:

For hand delivery or delivery via a parcel service:

Medicaid Behavioral Health Section  
P.O. Box 91030  
Baton Rouge, LA 70821-9030

Medicaid Behavioral Health Section  
Bienville Bldg., 7<sup>th</sup> Floor  
628 North 4<sup>th</sup> Street  
Baton Rouge, LA 70802

Fax: (225) 342-1972 or (225) 342-1973 or Toll Free at (866) 427-2148

The provider may be represented by an attorney or an authorized representative at the review. The attorney or authorized representative must file a written notice of representation identifying himself/herself by name, address, and telephone number at the address given above.

After the informal review is completed, the Bureau shall inform the provider in writing of the results and conclusions. The provider has the right to seek an administrative appeal of the sanction within thirty (30) days of the receipt of the results of the informal review.

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**CHAPTER 31: MENTAL HEALTH REHABILITATION**

**SECTION 31.10: ACRONYMS/DEFINITIONS**

**LCSW** - Licensed Clinical Social Worker

**LMHP** - Licensed Mental Health Professional

**LOCUS** – Level of Care Utilization Scale

**LPC** – Licensed Professional Counselor

**LPN** - Licensed Practical Nurse

**LRS**- Louisiana Rehabilitation Services

**MAR** – Medication Administration Record

**MBHS** – Medicaid Behavioral Health Section

**Mental Health Related Field** – An academic program with a curriculum content in which at least seventy percent (70%) of the required courses for the major field of study are based upon the core mental health disciplines.

**MHP** - Mental Health Professional

**MHR** - Mental Health Rehabilitation

**MHR Facility** – a location for services which includes the enrolled site or an off-site used exclusively for MHR recipients.

**MHRISIS** - Mental Health Rehabilitation Services Information System

**MHS** - Mental Health Specialist

**NP**-Nurse Practitioner

**OAD**-Office of Addictive Disorders

**OCDD**-Office of Citizens with Developmental Disorders

**OCS** – Office of Community Services

**OFS** – Office of Family Support

**OIG** – Office of the Inspector General