

RESIDENTIAL SERVICES

Therapeutic Group Homes

Therapeutic group homes (TGHs) provide a community-based residential service in a home-like setting of no greater than ten beds, under the supervision and program oversight of a psychiatrist or psychologist. TGHs are located in residential communities in order to facilitate community integration through public education, recreation and maintenance of family connections.

TGHs deliver an array of clinical and related services within the home, including psychiatric supports, integration with community resources and skill-building taught within the context of the home-like setting. The treatment should be targeted to support the restoration of adaptive and functional behaviors that will enable the child or adolescent to return to and remain successfully in his/her home and community, and to regularly attend and participate in work, school or training, at the child's best possible functional level. TGH treatment must target reducing the severity of the behavioral health issue that was identified as the reason for admission. Most often, targeted behaviors will relate directly to the child's or adolescent's ability to function successfully in the home and school environment (e.g., compliance with reasonable behavioral expectations, safe behavior and appropriate responses to social cues and conflicts, ability to communicate and problem-solve within family relationships), with a focus on skills that will generalize to the youth's next living situation (ideally, a permanent family home).

Treatment must:

- Focus on reducing the behavior and symptoms of the psychiatric disorder that necessitated the removal of the child or adolescent from his/her usual living situation;
- Decrease problem behavior and increase developmentally appropriate, normative and pro-social behavior in children and adolescents who are in need of out-of-home placement. As much as possible, this work should be done with the engagement of, and in the context of the family with whom the youth will live next, such that the skills learned to increase pro-social behavior are practiced within family relationships and so can be expected to generalize to the youth's next living situation; and

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- Transition the child or adolescent from TGH to home- or community-based living, with outpatient treatment (e.g., individual and family therapy).

Integration with community resources is an overarching goal of the TGH level of care, which is in part achieved through rules governing the location of the TGH facility, the physical space of the TGH facility, and the location of schooling for resident youth. The intention of the TGH level of care is to provide a 24-hour intensive treatment option for youth who need it, and to provide it in a location with more opportunities for community integration than can be found in other more restrictive residential placements (e.g., inpatient hospital psychiatric residential treatment facility (PRTF)). To enhance community integration, TGH facilities must be located within a neighborhood in a community, must resemble a family home as much as possible, and resident youth must attend community schools integrated in the community (as opposed to being educated at a school located on the campus of an institution). This array of services, including psychiatric supports, therapeutic services (individual counseling, family therapy, and group therapy), and skill-building, prepares the youth to return back to their community.

The State Medicaid agency or its designee must have determined that less intensive levels of treatment are unsafe, unsuccessful or unavailable. The child must require active treatment that would not be able to be provided at a less restrictive level of care being provided on a 24-hour basis with direct supervision/oversight by professional behavioral health staff. The setting must be geographically situated to allow ongoing participation of the child’s family. In this setting, the child or adolescent remains involved in community-based activities and may attend a community educational, vocational program or other treatment setting.

TGHs provide a 24 hours/day, seven days/week, structured and supportive living environment. Care coordination is provided to plan and arrange access to a range of educational and therapeutic services. Psychotropic medications should be used with specific target symptoms identification, with medical monitoring and 24-hour medical availability when appropriate and relevant. Screening and assessment is required upon admission. The psychologist or psychiatrist must see the member at least once, prescribe the type of care provided, and, if the services are not time-limited by the prescription, review the need for continued care every 28 days. Although the psychologist or psychiatrist does not have to be on the premises when his/her member is receiving covered services, the supervising practitioner must assume professional responsibility for the services provided and assure that the services are medically appropriate.

The individualized, strengths-based services and supports are:

- Identified in partnership with the child or adolescent and the family and support system, to the extent possible, and if developmentally appropriate;

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- Based on both clinical and functional assessments;
- Clinically monitored and coordinated, with 24-hour availability;
- Implemented with oversight from a licensed mental health professional; and
- Assist with the development of skills for daily living, and support success in community settings, including home and school.

Staffing schedules must reflect overlap in shift hours to accommodate information exchange for continuity of youth treatment, adequate numbers of staff reflective of the tone of the home, appropriate staff gender mix and the consistent presence and availability of professional staff on nights and weekends, when parents are available to participate in family therapy and to provide input on the treatment of their child.

The TGH is required to coordinate with the child’s or adolescent’s community resources, including schools with the goal of transitioning the youth out of the program to a less restrictive care setting for continued, sometimes intensive, services as soon as possible and appropriate. Discharge planning begins upon admission, with concrete plans for the child to transition back into the community beginning within the first week of admission with clear action steps and target dates outlined in the treatment plan. The treatment plan must include behaviorally measurable discharge goals.

Components

For treatment planning, the program must use a standardized assessment and treatment planning tool such as the Child and Adolescent Needs and Strengths (CANS) Comprehensive Assessment. The assessment protocol must differentiate across life domains, as well as risk and protective factors, sufficiently so that a treatment plan can be tailored to the areas related to the presenting problems of each youth and their family in order to ensure targeted treatment. The tool should also allow tracking of progress over time. The specific tools and approaches used by each program must be specified in the program description and are subject to approval by the State. In addition, the program must ensure that requirements for pretreatment assessment are met prior to treatment commencing. A TGH must ensure that youth are receiving appropriate therapeutic care to address assessed needs on the child’s treatment plan:

- Therapeutic care may include treatment by TGH staff, as well as community providers.

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- Treatment provided in the TGH or in the community should incorporate research-based approaches appropriate to the child’s needs, whenever possible; and
- The psychiatrist or psychologist/medical psychologist must provide 24-hour, on-call coverage seven days a week.

Provider Qualifications

Facilities that operate as TGHs must be licensed by the Louisiana Department of Health (LDH), provide community-based residential services in a home-like setting of no greater than ten beds, and under the supervision and oversight of a psychiatrist or licensed psychologist. A TGH must be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or The Joint Commission (TJC). Denial, loss of, or any negative change in accreditation status must be reported to their contracted managed care organizations (MCOs) in writing immediately upon notification by the accreditation body. TGH staff must be supervised by a licensed mental health professional (LMHP) with experience in evidence-based treatments and operating within their scope of practice license. LMHP staff also provide individual, family, and group therapy. Staff includes paraprofessional and bachelor’s level staff (who provide integration with community resources, skill building and peer support services) and master’s level staff (who provide individual, group, and family interventions) with degrees in social work, counseling, psychology or a related human services field, with oversight by a psychologist or psychiatrist. The human service field is defined as an academic program with a curriculum content in which at least 70 percent of the required courses are in the study of behavioral health or human behavior. A TGH must provide the minimum amount of active treatment hours established by the Department, and performed by qualified staff per week for each child, consistent with each child’s treatment plan and meeting assessed needs.

Additional Organizational Requirements

Facilities that operate as TGHs must:

- Arrange for and maintain documentation that all persons, prior to employment, pass criminal background checks through the Louisiana Department of Public Safety (DPS), State Police. If the results of any criminal background check reveal that the potential employee (or contractor) was convicted of any offenses against a child/youth or an elderly or disabled person, the provider must not hire and/or must terminate the employment (or contract) of such individual. The provider

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must not hire an individual with a record as a sex offender nor permit these individuals to work for the provider as a subcontractor. Criminal background checks must be performed as required by R.S. 40:1203 et seq., and in accordance with R.S. 15:587 et seq. Criminal background checks performed over 30 days prior to date of employment will not be accepted as meeting this requirement;

- Arrange for and maintain documentation that all persons, prior to employment, are free from tuberculosis (TB) in a communicable state via skin testing (or chest exam if recommended by physician) to reduce the risk of such infections in recipients and staff. Results from testing performed over 30 days prior to date of employment will not be accepted as meeting this requirement;
- Establish and maintain written policies and procedures inclusive of drug testing staff to ensure an alcohol and drug-free workplace and a workforce free of substance use (See Appendix D in this manual chapter);
- Maintain documentation that all direct care staff, who are required to complete first aid, cardiopulmonary resuscitation (CPR) and seizure assessment training, complete the training within 90 days of hire;
- Maintain documentation of verification of staff meeting educational and professional requirements, licensure (where applicable), as well as completion of required trainings for all staff; and
- Ensure and maintain documentation that all unlicensed persons employed by the organization complete training in a recognized crisis intervention curriculum prior to handling or managing crisis calls, which must be updated annually.

Agency

TGH facilities may specialize and provide care for sexually deviant behaviors, substance use or dually diagnosed individuals. If a program provides care to any of these categories of youth, the program must submit documentation to their contracted MCOs and the Coordinated System of Care (CSoc) contractor regarding the appropriateness of the research-based, trauma-informed programming and training, as well as compliance with the American Society of Addiction Medicine (ASAM) level of care being provided (if applicable).

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For service delivery, the program must incorporate at least one research-based approach pertinent to the sub-populations of TGH members to be served by the specific program. The specific research-based models to be used should be incorporated into the program description and submitted to the State for approval. All research-based programming in TGH settings must be approved by the State. All programs should also incorporate some form of research-based, trauma-informed programming and training.

Staffing for the facility must be consistent with State licensure regulations. For example, if State licensure requires a ratio of not less than one staff to five members be maintained at all times; then, two staff must be on duty at all times with at least one being direct care staff when there is a member present.

Staffing Qualifications

Individuals who provide TGH services must meet the following requirements:

- Direct care staff must be at least 18 years old and at least three years older than an individual under 18 years of age;
- Must have a high school diploma, general equivalency diploma or trade school diploma in the area of human services, or demonstrate competency or verifiable work experience in providing support to persons with disabilities. The human service field is defined as an academic program with a curriculum content in which at least 70 percent of the required courses are in the study of behavioral health or human behavior;
- Must have a minimum of two years of experience working with children, be equivalently qualified by education in the human services field, or have a combination of work experience and education with one year of education substituting for one year of experience;
- Must not have a finding on the Louisiana State Nurse Aide Registry and the Louisiana Direct Service Worker Registry against him/her;
- All unlicensed staff must be under the supervision and oversight of a psychiatrist or psychologist;

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- Pass criminal background check through DPS State Police prior to employment;
- Pass a TB test prior to employment;
- Pass drug screening tests as required by agency’s policies and procedures; and
- Complete American Heart Association (AHA) recognized First Aid, CPR and seizure assessment training. Psychiatrists, advanced practical registered nurses (APRNs)/clinical nurse specialists (CNSs)/physician assistants (PAs), registered nurses (RNs) and licensed practical nurses (LPNs) are exempt from this training. (See Appendix D of this manual chapter.)

Allowed Provider Types and Specialties

- PT AT Therapeutic Group Home PS 5X Therapeutic Group Home

Eligibility Criteria

The medical necessity for these rehabilitative services must be determined by and recommended by an LMHP or physician and under the direction of a licensed practitioner, to promote the maximum reduction of symptoms and/or restoration of an individual to his/her best age-appropriate functional level.

Less intensive levels of treatment must have been determined to be unsafe, unsuccessful or unavailable. The child must require active treatment provided on a 24-hour basis with direct supervision/oversight by professional behavioral health staff that would not be able to be provided at a less restrictive level of care.

Service Utilization

Licensed psychologists and LMHPs bill for their direct services separately under the approved State Plan for ‘Other Licensed Practitioners’. Supervision of unlicensed practitioners by licensed practitioners is built into the TGH rate.

TGHs are located in residential communities in order to facilitate community integration through public education, recreation and maintenance of family connections. The facility is expected to provide recreational activities for all enrolled children but not use Medicaid funding for payment of such non-Medicaid activities.

Service Exclusions

The following services/components must be excluded from Medicaid reimbursement:

- Components that are not provided to, or directed exclusively toward the treatment of, the Medicaid eligible individual;
- Services provided at a work site which are job tasks oriented and not directly related to the treatment of the recipient’s needs;
- 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 use treatment services;
- Services rendered in an institution for mental disease (IMD);
- Room and board; and
- Supervision associated with the child’s stay in the TGH.

Allowed Mode(s) of Delivery

- On-site

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Additional Service Criteria

The unit of service for reimbursement for the TGH is based on a daily rate for the services provided by unlicensed practitioners only.

TGHs may not be IMDs. Each organization owning TGHs must ensure that in no instance, does the operation of multiple TGH facilities constitute operation of an IMD. All new construction, newly acquired property or facilities or new provider organizations must comply with facility bed limitations not to exceed ten beds. Existing facilities may not add beds if the bed total would exceed ten beds in the facility. Any physical plant alterations of existing facilities must be completed in a manner to comply with the ten bed per facility limit (i.e., renovations of existing facilities exceeding ten beds must include a reduction in the bed capacity to ten beds).

The average length of stay ranges from 14 days to six months. TGH programs focusing on transition or short-term crisis are typically in the 14 to 30-day range. Discharge may be determined based on the child no longer making adequate improvement in this facility (and another facility being recommended) or the child no longer having medical necessity at this level of care. Continued TGH stay should be based on a clinical expectation that continued treatment in the TGH can reasonably be expected to achieve treatment goals and improve or stabilize the child's or adolescent's behavior, such that this level of care will no longer be needed and the child or adolescent can return to the community. Transition should occur to a more appropriate level of care (either more or less restrictive) if the child or adolescent is not making progress toward treatment goals, and there is no reasonable expectation of progress at this level of care (e.g., child's or adolescent's behavior and/or safety needs require a more restrictive level of care or, alternatively, child's or adolescent's behavior is linked to family functioning and can be better addressed through a family/home-based treatment).

TGH services will be inclusive of, but not limited to, the allowable cost of clinical and related services, psychiatric supports, integration with community resources and the skill-building provided by unlicensed practitioners. LMHPs must bill the MCOs for their services separately. In addition to the Medicaid per diem rate for treatment services, there is also a separate per diem room and board component to the rate that cannot be paid with Medicaid funds. This room and board rate is typically paid by the youth's custodian (in some cases a child-serving state agency) or another designated payment source.

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LMHPs bill for their services separately under the approved State Plan for “Other Licensed Practitioners”. Therapy (individual, group and family, whenever possible) and ongoing psychiatric assessment and intervention, as needed, (by a psychiatrist) are required of TGH, but provided and billed separately by licensed practitioners for direct time spent.

TGH Cost Reporting Requirements

Cost reports must be submitted annually. The due date for filing annual cost reports is the last day of the fifth month following the facility’s fiscal year end. Separate cost reports must be filed for the facilities central/home office when costs of that entity are reported on the facilities cost report. If the facility experiences unavoidable difficulties in preparing the cost report by the prescribed due date, a filing extension may be requested. A filing extension must be submitted to Medicaid prior to the cost report due date. Facilities filing a reasonable extension request will be granted an additional 30 days to file their cost report.

Psychiatric Residential Treatment Facilities

Psychiatric residential treatment facilities (PRTFs) are required to ensure that all medical, psychological, social, behavioral and developmental aspects of the member's situation are assessed and that treatment for those needs are reflected in the plan of care (POC) per 42 CFR 441.155. In addition, the PRTF must ensure that the resident receives all treatment needed for those identified needs. In addition to services provided by and in the facility, when they can be reasonably anticipated on the active treatment plan, the PRTF must ensure that the resident receives all treatment identified on the active treatment plan and any other medically necessary care required for all medical, psychological, social, behavioral and developmental aspects of the recipient's situation. The facility must provide treatment meeting State regulations per LAC 48: I. Chapter 90.

Services must meet active treatment requirements, which mean implementation of a professionally developed and supervised individual POC that is developed and implemented no later than 72 hours after admission and designed to achieve the recipient's discharge from inpatient status at the earliest possible time. “Individual POC” means a written plan developed for each member to improve his condition to the extent that inpatient care is no longer necessary.

Plan of Care (POC)

The POC must:

- Be based on a diagnostic evaluation conducted within the first 24 hours of admission in consultation with the youth and the parents/legal guardian that includes examination of the medical, psychological, social, behavioral and developmental aspects of the recipient's situation and reflects the need for inpatient psychiatric care;
- Be developed by a team of professionals specified under §441.156 in consultation with the child and the parents, legal guardians or others in whose care the youth will be released after discharge;
- State treatment objectives;
- Prescribe an integrated program of therapies, activities and experiences designed to meet the objectives; and
- Include, at an appropriate time, post-discharge plans and coordination of inpatient services, with partial discharge plans and related community services to ensure continuity of care with the member's family, school and community upon discharge.

The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to:

- Determine that services being provided are or were required on an inpatient basis; and
- Recommend changes in the plan, as indicated by the member's overall adjustment as an inpatient.

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The facility treatment team develops and reviews the individual POC. The individual POC must be developed by an interdisciplinary team of physicians and other personnel who are employed by, or provide services to, patients in the facility. Based on education and experience, preferably including competence in child psychiatry, the team must be capable of:

- Assessing the beneficiary's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities;
- Assessing the potential resources of the beneficiary's family;
- Setting treatment objectives; and
- Prescribing therapeutic modalities to achieve the plan's objectives.

Provider Qualifications

Agencies that operate as psychiatric residential treatment facilities (PRTFs) must:

- Be licensed by the Louisiana Department of Health (LDH) and accredited prior to enrollment by an LDH approved accrediting body: Commission on Accreditation of Rehabilitation Facilities (CARF), Council on Accreditation (COA) or The Joint Commission (TJC). Denial, loss of, or any negative change in accreditation status must be reported to their contracted managed care organizations (MCOs) in writing immediately upon notification by the accreditation body. The PRTF must be accredited prior to delivering services;
- PRTFs must submit a program description to the State inclusive of the specific research based models it will utilize for both treatment planning and service delivery. (See **Treatment Model and Service Delivery** section for more information.) PRTFs must have the Office of Behavioral Health (OBH) approval of the PRTF program description and research model(s) prior to enrolling with Medicaid or executing a provider agreement or contract with a Medicaid managed care entity(ies); and
- PRTFs must have OBH approval of the auditing body(ies) providing Evidence-Based Practice (EBP) and/or ASAM fidelity monitoring. PRTFs must submit fidelity monitoring documentation annually demonstrating compliance with at least two EBPs and/or ASAM criteria.

Agency

Facilities that operate as PRTFs must meet the additional organizational requirements:

- Arrange for criminal background checks and maintain documentation for any applicant for employment, contractor, volunteer and other person who will provide services to the residents prior to that person working at the facility. If the results of any criminal background check reveal that the potential employee, volunteer or contractor was convicted of any offenses against a child/youth or an elderly or disabled person, the provider must not hire and/or must terminate the employment (or contract) of such individual. The provider must not hire an individual with a record as a sex offender nor permit these individuals to work for the provider as a subcontractor. Criminal background checks must be performed as required by R.S. 40:1203 et seq., and in accordance with R.S. 15:587 et seq. Criminal background checks performed over 30 days prior to the date of employment will not be accepted as meeting this requirement;
- The PRTF is also restricted from knowingly employing and/or contracting with a person who has a finding placed on the Louisiana State Nurse Aide Registry or the Louisiana Direct Service Worker Registry;
- Arrange for and maintain documentation that all persons, prior to employment, are free from tuberculosis (TB) in a communicable state via skin testing (or chest exam if recommended by physician) to reduce the risk of such infections in recipients and staff. Results from testing performed over 30 days prior to date of employment will not be accepted as meeting this requirement;
- Establish and maintain written policies and procedures inclusive of drug testing staff to ensure an alcohol and drug-free workplace and a workforce free of substance use. (See Appendix D of this manual chapter);
- Maintain documentation that all direct care staff, who are required to complete First Aid, cardiopulmonary resuscitation (CPR) and seizure assessment training, complete American Heart Association (AHA) recognized training within 90 days of hire, which must be renewed within a time period recommended by the AHA. (See Appendix D of this manual chapter); and

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- Maintain documentation verifying that staff meet educational and professional requirements, licensure (where applicable), as well as completion of required trainings.

PRTFs must comply with federal emergency preparedness regulations associated with 42 CFR §441.184 in order to participate in the Medicare or Medicaid program. Regulations must be implemented by November 15, 2017. They include safeguarding human resources, maintaining business continuity and protecting physical resources. (<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html>)

Facilities should incorporate the four elements of emergency preparedness into their plans and comply with all components of the federal regulation:

- **Risk assessment and emergency planning** - CMS requires facilities to perform a risk assessment that uses an “all-hazards” approach prior to establishing an emergency plan.
- **Communication plan** - CMS requires facilities to develop and maintain an emergency preparedness communication plan that complies with both federal and state laws. Patient care must be well coordinated within the facility, across healthcare providers, and with state and local public health departments and emergency management agencies and systems to protect patient health and safety in the event of a disaster.
- **Policies and procedures** - CMS requires that facilities develop and implement policies and procedures that comply with federal and state law, and that support the successful execution of the emergency plan and risks identified during the risk assessment process.
- **Training and testing** - CMS requires that facilities develop and maintain an emergency preparedness training and testing program that complies with federal and state law, and that is updated at least annually.

Staff

All experience requirements are related to paid experience. Volunteer work, college work/study or internship related to completion of a degree cannot be counted as work experience. If experience is in a part-time position, the staff person must be able to verify the amount of time

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worked each week. Experience obtained while working in a position for which the individual is not qualified may not be counted as experience.

To provide services in a PRTF, staff must meet the following requirements:

- Pass criminal background check through the DPS, State Police prior to employment;
- Pass a TB test prior to employment;
- Pass drug screening tests as required by agency's policies and procedures;
- Complete American Heart Association (AHA) recognized First Aid, CPR and seizure assessment training. Psychiatrists, advanced practical registered nurses (APRNs)/clinical nurse specialists (CNSs)/physician assistants (PAs), registered nurses (RNs) and licensed practical nurses (LPNs) are exempt from this training. (See Appendix D of this manual chapter); and
- Complete all required training appropriate to the program model approved by OBH.

Staffing Qualifications

Per federal regulations at 42 CFR 441.156 and state regulations at LAC 48: I. Chapter 90.9083.C, the team must include, as a minimum, either:

- A board-eligible or board-certified psychiatrist;
- A clinical psychologist and a physician licensed to practice medicine or osteopathy; and
- A physician licensed to practice medicine or osteopathy, with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been licensed by the State psychological association. Note: Louisiana does not consider individuals with a master's degree in clinical psychology to practice and be considered "psychologists". Facilities wishing to utilize this option under federal and state regulations must ensure that State psychology scope of practice

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is followed. In this case it would mean that the psychologist must be a licensed or medical psychologist.

The team must also include one of the following:

- A licensed clinical social worker (LCSW);
- A RN with specialized training or one year's experience in treating mentally ill individuals;
- An occupational therapist who is licensed, if required by the State, and who has specialized training or one year of experience in treating mentally ill individuals; and/or
- A psychologist who is licensed by the State psychological association. Louisiana does not consider individuals with a master's degree in clinical psychology to practice and be considered "psychologists". Facilities wishing to utilize this option under federal and state regulations must ensure that State psychology scope of practice is followed. In this case it would mean that the psychologist must be a licensed or medical psychologist.

Note: In all cases, it is preferred that team members also have experience treating children and adolescents.

Treatment Model and Service Delivery

Because the PRTF is not in itself a specific research-based model, it must instead incorporate research-based models developed for a broader array of settings that respond to the specific presenting problems of the members served. Each PRTF program should incorporate appropriate research-based programming for both treatment planning and service delivery.

For milieu management, all programs should also incorporate some form of research-based, trauma-informed programming and training, if the primary research-based treatment model used by the program does not have it (e.g., the Louisiana Model for Secure Care - LAMod). Annually, facilities must submit documentation demonstrating compliance with at least two EBP fidelity monitoring or ASAM criteria. OBH must approve the auditing body providing the EBP/ASAM fidelity monitoring. PRTF may specialize and provide care for sex offenders, substance use treatment or individuals with co-occurring disorders. If a program provides care to any of these categories of youth, the program must submit documentation regarding the

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appropriateness of the research-based, trauma-informed programming and training, as well as compliance with the ASAM level of care being provided.

In addition, programs may propose other models, citing the research base that supports use of that model with the target population (e.g., gender-specific approaches). They may also work with the purveyors of research-based models to develop more tailored approaches, incorporating other models.

The specific research-based models to be used should be incorporated into the program description and submitted to the State for approval by the MCO, subject to OBH review. All research-based programming in PRTF settings must be approved by the State.

Staffing for the facility must be consistent with State licensure regulations on a full-time employee (FTE) basis. For example, if State licensure requires a staff to member ratio of 1:25 and the facility has 16 child residents, then the facility must have at least .64 FTE for the 16 children. If the facility has eight beds, then the facility must have at least .32 FTE for the eight children.

Prior to admission, the MCO team, including a physician with competence in diagnosis and treatment of mental illness, preferably in child psychiatry and has knowledge of the individual's situation, must certify that:

- Ambulatory care resources available in the community do not meet the treatment needs of the recipient;
- Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
- The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

Children/adolescents receiving services in a PRTF program must have access to education services, including supports to attend public school if possible, or in-house educational components, or vocational components if serving adolescents. Educational/vocational expenses are not Medicaid expenses. In addition, supports to attend public school outside of the PRTF are not considered activities provided by and in the PRTF and on the active treatment plan, and may not be reimbursed by Medicaid. However, supports to attend in-house education/vocational components may be reimbursed by the PRTF utilizing Medicaid funding to the extent that it is therapy to support education in a PRTF (e.g., occupational therapy (OT), physical therapy (PT),

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speech therapy (ST), etc.). Medicaid funding for the education itself is not permitted. Medicaid will pay for the therapies associated with the education provided in-house while the child is in a PRTF.

Allowed Provider Types and Specialties

- PT 96 Psychiatric Residential Treatment Facility, PS 9B Psychiatric Residential Treatment Facility
- PT 96 Psychiatric Residential Treatment Facility, PS 8U Substance Use or Addiction
- PT 96 Psychiatric Residential Treatment Facility, PS 8R Other Specialization

Eligibility Criteria

Children under 21 years of age, pre-certified by an independent team employed by the MCO, where:

- Ambulatory care resources available in the community do not meet the treatment needs of the member;
- Proper treatment of the member's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
- The services can be reasonably expected to improve the member's condition or prevent further regression, so that the services will no longer be needed.

The independent MCO team pre-certifying the PRTF stay must:

- Include a physician;
- Have competence in diagnosis and treatment of mental illness, preferably in child psychiatry; and
- Have knowledge of the individual's situation.

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Limitations/Exclusions

The facility must comply with seclusion and restraint requirements found at LAC 48:I.Chapter 90 and 42 CFR 483 subpart G.

Reasonable activities include PRTF treatment provided by and in the facility when it was found, during the initial evaluation or subsequent reviews, to be treatment necessary to address a medical, psychological, social, behavioral or developmental aspect of the child’s care per 42 CFR 441.155. The PRTF reasonable activities are child-specific and must be necessary for the health and maintenance of health of the child while he or she is a resident of the facility. The medically necessary care must constitute a need that contributes to the inpatient treatment of the child and is dependent upon the expected length of stay of the particular child in that facility (e.g., dental hygiene may be necessary for a child expected to reside in the facility for 12 months but not 30 days).

Allowed Mode(s) of Delivery

- On-site.

Additional Service Criteria

Services for Medicaid-eligible residents not provided by and in the facility and reflected on the active treatment plan are not reimbursable by Medicaid.

Reimbursement

Reimbursement for PRTF is based on the following criteria:

- Each PRTF provider must enter into a contract with one or more managed care organization in order to receive reimbursement for Medicaid services;
- LDH or its fiscal intermediary must make monthly capitation payments to the MCOs, and the MCOs will determine the rates paid to its contracted providers. Payment must be no less than the minimum Medicaid rate; and
- Covered inpatient PRTF activities for individuals under twenty-one years of age must be reimbursed by Medicaid.

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Free-standing PRTFs

The rate for free-standing PRTFs must include reimbursement for the following services when included on the active treatment plan:

- Occupational therapy/physical therapy/speech therapy;
- Laboratory; and
- Transportation.

A free-standing PRTF must arrange through contract(s) with outside providers to furnish dental, vision, and diagnostic/radiology treatment activities as listed on the active treatment plan. The treating provider will be directly reimbursed by the MCO.

In-State PRTF Reimbursement Rates

In-State publicly or privately owned and operated PRTFs must be reimbursed for covered PRTF services according to the following provisions. The rate paid by the MCO to the provider must take into consideration the following ownership and service criteria:

- Free-standing privately owned and operated PRTF specializing in sexually-based treatment programs;
- Free-standing privately owned and operated PRTF specializing in substance use treatment programs;
- Free-standing privately owned and operated PRTF specialized in behavioral health treatment programs;

Out-of-State PRTF Reimbursement Rates

Out of state psychiatric residential treatment facilities must be reimbursed in accordance with the MCO contractor’s established rate.

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Cost Reports (PRTF)

All in-state Medicaid-participating PRTF providers are required to:

- File an annual Medicaid cost report in accordance with Medicare/Medicaid allowable and non-allowable costs;
- Submit cost reports on or before the last day of the fifth month after the end of the provider’s fiscal year end;
- Separate cost reports must be submitted by central/home offices when costs of the central/home office are reported in the PRTF provider’s cost report; and
- Submit a filing extension to LDH prior to the cost report due date if the PRTF provider experiences unavoidable difficulties in preparing the cost report by the prescribed due date.

NOTE: Facility filing a reasonable extension request will be granted an additional 30 days to file their cost reports.

Level 3.7 Medically Monitored Intensive Residential Treatment – Adolescent

This is a PRTF level of care for co-occurring disorder (COD) treatment that provides 24 hours of structured activities per week including, but not limited to:

- Psychiatric and substance use assessments;
- Diagnosis treatment; and
- Habilitative and rehabilitation services.

These services are provided to individuals with co-occurring psychiatric and substance disorders (ICOPSD), whose disorders are of sufficient severity to require a residential level of care.

All facilities are licensed by LDH and must be accredited prior to enrollment by an LDH approved national accrediting body: CARF, COA or TJC. Denial, loss of, or any negative change in accreditation status must be reported to their contracted MCOs in writing immediately upon notification by the accreditation body.

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It also provides a planned regiment of 24-hour professionally directed evaluation, observation and medical monitoring of addiction and mental health treatment in a residential setting. They feature permanent facilities, including residential beds, and function under a defined set of policies, procedures and clinical protocols. Appropriate for members whose subacute biomedical and emotional, behavior or cognitive problems are so severe that they require co-occurring capable or enhanced residential treatment, but who do not need the full resources of an acute care general hospital. In addition to meeting integrated service criteria, COD treatment providers must have experience and preferably licensure and/or certification in both addictive disorders and mental health. Children/adolescents receiving services in a PRTF program must have access to education services, including supports to attend public school if possible, or in-house educational components or vocational components if serving adolescents. Educational/vocational expenses are not Medicaid expenses. In addition, supports to attend public school outside of the PRTF are not considered activities provided by and in the PRTF and on the active treatment plan, and may not be reimbursed by Medicaid. However, supports to attend in-house education/vocational components may be reimbursed by the PRTF utilizing Medicaid funding to the extent that it is therapy to support education in a PRTF (e.g., OT, PT, ST. etc.). Medicaid funding for the education itself is not permitted. Medicaid will pay for the therapies associated with the education provided in-house while the child is in a PRTF.

Admission Guidelines (PRTFs)

Individuals in this level of care may have co-occurring addiction and mental health disorders that meet the eligibility criteria for placement in a co-occurring-capable program or difficulties with mood, behavior or cognition related to a substance use or mental disorder, or emotional behavioral or cognitive symptoms that are troublesome, but do not meet the DSM criteria for mental disorder. Admission guidelines for PRTF services are:

- Acute intoxication and/or withdrawal potential – None or minimal/stable withdrawal risk;
- Biomedical conditions and complications – Moderate to severe conditions (which require 24-hour nursing and medical monitoring or active treatment but not the full resource of an acute care hospital);
- Emotional, behavioral or cognitive conditions and complications – Moderate to severe conditions and complications. These symptoms may not be severe enough to meet diagnostic criteria but interfere or distract from recovery efforts (for example, anxiety/hypomanic or depression and/or cognitive symptoms, which may include compulsive behaviors, suicidal or homicidal ideation, with a recent

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history of attempts but no specific plan, or hallucinations and delusions without acute risk to self or others) are interfering with abstinence, recovery and stability to such a degree that the individual needs a structured 24-hour, medically monitored (but not medically managed) environment to address recovery efforts;

- Readiness to change – Member is in need of intensive motivating strategies, activities and processes available only in a 24-hour structured medically monitored setting (but not medically managed);
- Relapse, continued use or continued problem potential – Member is experiencing an escalation of relapse behaviors and/or acute psychiatric crisis and/or reemergence of acute symptoms and is in need of 24-hour monitoring and structured support; and
- Recovery environment – Environment or current living arrangement is characterized by a high risk of initiation or repetition of physical, sexual or emotional abuse or substance use so endemic that the patient is assessed as unable to achieve or maintain recovery at a less intensive level or care.

Screening/Assessment/Treatment Plan Review (PRTF)

A triage screening must be completed to determine eligibility and appropriateness (proper patient placement) for admission and referral. (The MCO ensures that pre-certification requirements are met.)

A comprehensive bio-psychosocial assessment must be completed within seven days, which substantiates appropriate patient placement. The assessment must be reviewed and signed by a qualified professional. The following sections must be completed prior to seven days of admission:

- Medical;
- Psychological;
- Alcohol; and
- Drug.

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An individualized, interdisciplinary treatment plan, must be completed which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals. This plan should be developed in collaboration with the member and meet the following criteria:

- The treatment plan is reviewed/updated in collaboration with the member, as needed, or at a minimum of every 30 days;
- Discharge/transfer planning must begin at admission; and
- Referral arrangements made prior to discharge.

Provider Qualifications

Agency

To provide PTRF level of care services, agencies must meet the following requirements:

- Licensed as a PRTF by LDH per LAC 48: I. Chapter 90;
- Physician directed and meet the requirements of 42 CFR 441.151, including requirements referenced therein to 42 CFR 483 subpart G;
- Arrange for criminal background checks and maintain documentation for any applicant for employment, contractor, volunteer and other person who will provide services to the residents prior to that person working at the facility. If the results of any criminal background check reveal that the potential employee, volunteer or contractor was convicted of any offenses against a child/youth or an elderly or disabled person, the provider must not hire and/or must terminate the employment (or contract) of such individual. The provider must not hire an individual with a record as a sex offender nor permit these individuals to work for the provider as a subcontractor. Criminal background checks must be performed as required by R.S. 40:1203 et seq., and in accordance with R.S. 15:587 et seq. Criminal background checks performed over 30 days prior to the date of employment will not be accepted as meeting this requirement;

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- The PRTF is restricted from knowingly employing and/or contracting with a person who has a finding placed on the Louisiana State Nurse Aide Registry or the Louisiana Direct Service Worker Registry;
- Arrange for and maintain documentation that all persons, prior to employment, are free from Tuberculosis (TB) in a communicable state via skin testing (or chest exam if recommended by physician) to reduce the risk of such infections in recipients and staff. Results from testing performed over 30 days prior to date of employment will not be accepted as meeting this requirement;
- Establish and maintain written policies and procedures inclusive of drug testing staff to ensure an alcohol and drug-free workplace and a workforce free of substance use (See Appendix D);
- Maintain documentation that all direct care staff, who are required to complete First Aid, cardiopulmonary resuscitation (CPR) and seizure assessment training, complete American Heart Association (AHA) recognized training within 90 days of hire, which must be renewed within a time period recommended by the AHA. (See Appendix D.); and
- Maintain documentation of verification of staff meeting educational and professional requirements, licensure (where applicable), as well as completion of required trainings for all staff.

As required by CMS Emergency Preparedness Final Rule effective November 16, 2016, PRTFs must comply with Emergency Preparedness regulations associated with 42 CFR §441.184 in order to participate in the Medicare or Medicaid program (Link to CMS Emergency Preparedness Regulation Guidance and Resources: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html>). Regulations must be implemented by November 15, 2017. They include safeguarding human resources, maintaining business continuity and protecting physical resources.

Facilities should incorporate the following four core elements of emergency preparedness into their plans and comply with all components of the Rule:

- **Risk assessment and emergency planning** – CMS requires facilities to perform a risk assessment that uses an “all-hazards” approach prior to establishing an emergency plan.

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- **Communication plan** – CMS requires facilities to develop and maintain an emergency preparedness communication plan that complies with both federal and state laws. Patient care must be well coordinated within the facility, across healthcare providers, and with state and local public health departments and emergency management agencies and systems to protect patient health and safety in the event of a disaster.
- **Policies and procedures** – CMS requires that facilities develop and implement policies and procedures that comply with federal and state law, and that support the successful execution of the emergency plan and risks identified during the risk assessment process.
- **Training and testing** – CMS requires that facilities develop and maintain an emergency preparedness training and testing program that complies with federal and state law, and that is updated at least annually.

Staff

All experience requirements are related to paid experience. Volunteer work, college work/study or internship related to completion of a degree cannot be counted as work experience. If experience is in a part-time position, the staff person must be able to verify the amount of time worked each week. Experience obtained while working in a position for which the individual is not qualified may not be counted as experience. Staff who provide services in a PRTF setting must:

- Pass criminal background check through the Louisiana Department of Public Safety, State Police prior to employment;
- Pass a TB test prior to employment;
- Pass drug screening tests as required by agency’s policies and procedures;
- Complete American Heart Association (AHA) recognized First Aid, CPR and seizure assessment training. Psychiatrists, APRNs/CNSs/PAs, RNs and LPNs are exempt from this training (See Appendix D); and
- Complete all required training appropriate to the program model approved by OBH.

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The facility must have qualified professional medical, nursing and other support staff necessary to provide services appropriate to the bio-psychosocial needs of individuals being admitted to the program.

The provider must ensure that:

- There is a MD, medical director – MD(s) on site as needed for management of psychiatric/medical needs. 24 hour on-call availability;
- There is a psychologist available as needed;
- There is Nursing staff present – One FTE Supervisor (APRN/NP/RN), 24 hour on-call availability;
- There is one FTE RN/LPN available on site 7am-11pm;
- There is a licensed or certified clinician or counselor with direct supervision by an LMHP, or unlicensed professional (UP) under supervision of a QPS– one clinician per eight clients;
- There is Direct care aide staff available – Two FTE PA’s on all shifts. Ratio cannot exceed 1:8. Ratio must be 1:3 on therapy outings;
- There is clerical support staff available – 1 to 2 FTE per day shift;
- There is an activity/occupational therapist – one FTE;
- There is a care coordinator – one FTE per day shift, and/or duties may be assumed by clinical staff;
- An outreach worker/peer mentor is recommended;
- Physicians, who are available 24 hours a day by telephone. (A PA may perform duties within the scope of his/her practice as designated by physician). An APRN may perform duties within the scope of his/her practice;

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- Licensed, certified or registered clinicians provide a planned regimen of 24-hour, professionally directed evaluation, care and treatment services for individuals and their families;
- An interdisciplinary team of appropriately trained clinicians, such as physicians, nurses, counselors, social workers and psychologists is available to assess and treat the individual and to obtain and interpret information regarding the patient’s needs. The number and disciplines of team members are appropriate to the range and severity of the individual’s problems;
- An LMHP is available on site 40 hours per week;
- Qualified professional supervisor is available for clinical supervision and by telephone for consultation; and
- Caseloads not to exceed 8 members.

Allowed Provider Types and Specialties

- PT 96 Psychiatric Residential Treatment Facility, PS 8U Substance Use or Addiction.

Level 3.7-WM Medically Monitored Residential Withdrawal Management – Adolescent

Medically monitored residential withdrawal management is an organized service delivered by medical and nursing professionals, which is provided for 24-hour medically supervised evaluation under a defined set of physician-approved policies and physician-monitored procedures or clinical protocols.

All facilities are licensed by LDH and accredited prior to enrollment by an LDH approved national accrediting body: CARF, COA or TJC. Denial, loss of, or any negative change in accreditation status must be reported to their contracted MCOs in writing immediately upon notification by the accreditation body. Children/adolescents receiving services in a PRTF program must have access to education services, including supports to attend public school if possible, or in-house educational components or vocational components, if serving adolescents. Educational/vocational expenses are not Medicaid expenses.

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In addition, supports to attend public school outside of the PRTF are not considered activities provided by and in the PRTF and on the active treatment plan, and may not be reimbursed by Medicaid. However, supports to attend in-house education/vocational components may be reimbursed by the PRTF utilizing Medicaid funding to the extent that it is therapy to support education in a PRTF (e.g., OT, PT, ST. etc.). Medicaid funding for the education itself is not permitted. Medicaid will pay for the therapies associated with the education provided in-house while the child is in a PRTF.

Admission Guidelines (Medically Monitored Residential Withdrawal Management – Adolescent)

Medically Monitored Residential Withdrawal Management – Adolescent level of care services provides care to patients whose withdrawal signs and symptoms are sufficiently severe to require 24-hour inpatient care. This level sometimes is provided by overlapping with Level 4WM services as a “step-down” service from a specialty unit of an acute care general or psychiatric hospital. Twenty-four-hour observation, monitoring and treatment are available. However, the full resources of an acute care general hospital or a medically managed intensive inpatient treatment program are not necessary.

Screening/Assessments/Treatment Plan Review (PRTF)

A triage screening must be completed to determine eligibility and appropriateness (proper patient placement) for admission and referral. (The MCO ensures that pre-certification requirements are met.)

Must obtain approval of admission by a physician. A physical examination by a physician, PA or NP within 24 hours of admission must be complete, and appropriate laboratory and toxicology tests. A physical examination must be conducted within 24 hours prior to admission and may be used if reviewed and approved by the admitting physician.

A comprehensive bio-psychosocial assessment must be completed within seven days of admission, which substantiates appropriate patient placement. The assessment must be reviewed and signed by a qualified professional (exclusions: withdrawal management programs are not required to complete a psychosocial assessment but must screen for proper patient placement and referral).

An individualized, interdisciplinary stabilization/treatment plan should be developed in collaboration with the member, including problem identification in ASAM Dimensions 2-6.

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Discharge/transfer planning must begin at admission and referral arrangements should be made, as needed. A daily assessment of the member’s progress should be made, which should be documented accordingly.

Provider Qualifications

Agency

To provide Medically Monitored Residential Withdrawal Management – Adolescent level of care, PTRFs must meet the following requirements:

- Licensed as a PRTF by LDH per LAC 48: I. Chapter 90;
- Physician directed and meet the requirements of 42 CFR 441.151, including requirements referenced therein to 42 CFR 483 subpart G;
- Arrange for criminal background checks and maintain documentation for any applicant for employment, contractor, volunteer and other person who will provide services to the residents prior to that person working at the facility. If the results of any criminal background check reveal that the potential employee, volunteer or contractor was convicted of any offenses against a child/youth or an elderly or disabled person, the provider must not hire and/or must terminate the employment (or contract) of such individual. The provider must not hire an individual with a record as a sex offender nor permit these individuals to work for the provider as a subcontractor. Criminal background checks must be performed as required by R.S. 40:1203 et seq., and in accordance with R.S. 15:587 et seq. Criminal background checks performed over 30 days prior to the date of employment will not be accepted as meeting this requirement;
- The PRTF is also restricted from knowingly employing and/or contracting with a person who has a finding placed on the Louisiana State Nurse Aide Registry or the Louisiana Direct Service Worker Registry;
- Arrange for and maintain documentation that all persons, prior to employment, are free from Tuberculosis (TB) in a communicable state via skin testing (or chest exam if recommended by physician) to reduce the risk of such infections in recipients and staff. Results from testing performed over 30 days prior to date of employment will not be accepted as meeting this requirement;

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- Establish and maintain written policies and procedures inclusive of drug testing staff to ensure an alcohol and drug-free workplace and a workforce free of substance use. (See Appendix D.);
- Maintain documentation that all direct care staff, who are required to complete First Aid, cardiopulmonary resuscitation (CPR) and seizure assessment training, complete American Heart Association (AHA) recognized training within ninety (90) days of hire, which must be renewed within a time period recommended by the AHA. (See Appendix D.); and
- Maintain documentation of verification of staff meeting educational and professional requirements, licensure (as applicable), as well as completion of required trainings for all staff.

PRTFs must submit a program description to the State inclusive of the specific research based models it will utilize for both treatment planning and service delivery. (See Treatment Model and Service Delivery section for more information.) PRTFs must have OBH approval of the PRTF program description and research model(s) prior to enrolling with Medicaid or executing a provider agreement or contract with a Medicaid managed care entity(ies).

PRTFs must have OBH approval of the auditing body(ies) providing Evidenced-Based Practice (EBP) and/or ASAM fidelity monitoring. PRTFs must submit fidelity monitoring documentation annually demonstrating compliance with at least two EBPs and/or ASAM criteria.

As required by CMS Emergency Preparedness Final Rule effective November 16, 2016, PRTFs must comply with Emergency Preparedness regulations associated with 42 CFR §441.184 in order to participate in the Medicare or Medicaid program (Link to CMS Emergency Preparedness Regulation Guidance and Resources: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html>). Regulations must be implemented by November 15, 2017. They include safeguarding human resources, maintaining business continuity and protecting physical resources.

Facilities should incorporate the following four core elements of emergency preparedness into their plans and comply with all components of the Rule:

- **Risk assessment and emergency planning** – CMS requires facilities to perform a risk assessment that uses an “all-hazards” approach prior to establishing an emergency plan.

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- **Communication plan** – CMS requires facilities to develop and maintain an emergency preparedness communication plan that complies with both federal and state laws. Patient care must be well coordinated within the facility, across healthcare providers, and with state and local public health departments and emergency management agencies and systems to protect patient health and safety in the event of a disaster.
- **Policies and procedures** – CMS requires that facilities develop and implement policies and procedures that comply with federal and state law, and that support the successful execution of the emergency plan and risks identified during the risk assessment process.
- **Training and testing** – CMS requires that facilities develop and maintain an emergency preparedness training and testing program that complies with federal and state law, and that is updated at least annually.

For inpatient levels of care, a staffing ratio of 1:4 during awake hours (day and evening shifts) is typical, with an emphasis on nursing staff. The Joint Commission does not specify a ratio for adolescent residential treatment. Research and clinical experience regarding therapeutically effective residential care established the 1:4 ratios for mental health workers, as a minimum, in addition to a 1:6 requirements for mental health professionals.

Staff

All experience requirements are related to paid experience. Volunteer work, college work/study or internship related to completion of a degree cannot be counted as work experience. If experience is in a part-time position, the staff person must be able to verify the amount of time worked each week. Experience obtained while working in a position for which the individual is not qualified may not be counted as experience. Staff who provide Medically Monitored Residential Withdrawal Management – Adolescent level of care in a PRTF setting must:

- Pass criminal background check through the Louisiana Department of Public Safety, State Police prior to employment;
- Pass a TB test prior to employment;
- Pass drug screening tests as required by agency’s policies and procedures;

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- Complete American Heart Association (AHA) recognized First Aid, CPR and seizure assessment training. Psychiatrists, APRNs/CNSs/PAs, RNs and LPNs are exempt from this training (See Appendix D); and
- Complete all required training appropriate to the program model approved by OBH.

Facility must have qualified professional medical, nursing and other support staff necessary to provide services appropriate to the bio-psychosocial needs of individuals being admitted to the program.

The provider must ensure that:

- There is a physician (MD), MD(s) on site as needed for management of psychiatric and/medical needs;
- There are MD(s) available on call 24/7;
- There is a psychologist available as needed;
- Nurse (NP/RN or LPN) – 1 FTE Supervisor APRN/NP /RN, on call 24/7; 2FTE NP/RN/LPN on 1st and 2nd shifts and 1 LPN 3rd shift 1:8 ratio;
- There is a LMHP or UP under the supervision of a QPS – one clinician per 10 members and available 40 hours per week. A counselor is available 40 hours per week;
- There are direct care aides available – Two DCAs on all shifts. Not to exceed 1:10 ratio;
- There are clerical support staff – One to two FTE per day shift;
- Activity/occupational therapist – NA;
- Care coordinator – One FTE per day shift, and/or duties may be assumed by clinical staff; and
- There is an outreach worker/peer mentor – Optional.

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- Physicians are available 24 hours a day by telephone;
- A physician is available to assess the individual within 24 hours of admission (or earlier, if medically necessary) and is available to provide on-site monitoring of care and further evaluation on a daily basis;
- A RN or other licensed and credentialed nurse is available on-call 24 hours per day and on site no less than 40 hours per week and will conduct a nursing assessment on individuals at admission;
- A nurse is responsible for overseeing the monitoring of the individual's progress and medication administration on an hourly basis, if needed;
- Appropriately licensed and credentialed staff is available to administer medications in accordance with physician orders. The level of nursing care is at a ratio of one nurse per every 8 individuals;
- Licensed, certified or registered clinicians provide a planned regimen of 24-hour, professionally directed evaluation, care and treatment services for individuals and their families;
- An interdisciplinary team of appropriately trained clinicians, such as physicians, nurses, counselors, social workers and psychologists is available to assess and treat the individual and to obtain and interpret information regarding the patient's needs. The number and disciplines of team members are appropriate to the range and severity of the individual's problems;
- A LMHP is available on site 40 hours per week to provide direct member care, utilizing the 12 core functions of substance use counseling and/or specific functions related to professional license. Caseloads not to exceed 10 members; and
- A qualified professional supervisor is available for clinical supervision and by telephone for consultation.

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Allowed Provider Types and Specialties

- PT 96 Psychiatric Residential Treatment Facility, PS 8U Substance Use or Addiction.

Minimum Standards of Practice

- **Toxicology and drug screening** – Toxicology and drug screening are medically monitored. Physician may waive drug screening if and when individual signs a list of drugs being used and understands that his/her dishonesty could result in severe medical reactions during withdrawal management process.
- **Stabilization plan** - A qualified professional must identify the individual's short-term needs based on the withdrawal management history, the medical history and the physical examination, if available, and prepare a plan of action until individual becomes physically stable.
- **Withdrawal management and treatment plan** - The withdrawal management/treatment plan is medically monitored and must be reviewed and signed by the physician and the individual and must be filed in the individual's record within 24 hours of admission with updates, as needed.
- **Withdrawal management progress notes** - The program must implement the withdrawal management/treatment plan and document the individual's response to and/or participation in scheduled activities. Notes must include:
 - The individual's physical condition, including vital signs;
 - The individual's mood and behavior;
 - Statements about the individual's condition and needs;
 - Information about the individual's progress or lack of progress in relation to withdrawal management/treatment goals; and
 - Additional notes must be documented, as needed.
- **Physicians' orders** – Physicians' orders are required for medical and psychiatric management.