

# **MENTAL HEALTH REHABILITATION SERVICES PROVIDER MANUAL**

*Chapter Thirty-One of the Medical Services Manual*

## **LOUISIANA MEDICAID PROGRAM**

Department Of Health And Hospitals  
Bureau Of Health Services Financing



**Issued April 1, 2009**

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Licensed Clinical Social Worker  
Licensed Professional Counselor  
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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, the Office of Mental Health (OMH), and the network of certified and enrolled providers.

The Bureau is the Louisiana Medicaid Program. The Bureau develops program rules, regulations, policies, and procedures for the operation of the program. It provides funding for the reimbursement of prior authorized services to certified and enrolled providers. Contact information:

BHSF/Program Operations/MHR Program  
P.O. Box 91030  
Baton Rouge, LA 70821-9030  
Voice: 225-342-0124 Fax: 225-342-9462

The Office of Mental Health, through an agreement with the Bureau, manages the operation of the program through prior authorizing services, certifying new providers, recertifying enrolled providers, monitoring providers, and training activities. Contact information:

The Office of Mental Health  
1885 Wooddale Blvd., 9<sup>th</sup> Floor  
Baton Rouge, LA 70806  
Voice: 225-922-0006 Fax: 225-925-4789

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

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

Provider Enrollment Unit:  
Voice: 225-216-6370

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

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

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

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

MHR services are expected to achieve the following outcomes:

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

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

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

**Mandatory Services**

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

**Optional Services**

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

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

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

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

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

### **Screening for Medical Necessity**

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

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

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

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

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

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

*and*

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

*and*

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

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

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

**Children/Youth Criteria for Services**

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

- **Diagnosis.** The recipient must currently have or, at any time during the past year, had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet the diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) or the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM), or subsequent revisions of these documents. The diagnostic criteria specified under DSM-IV-TR “V” codes, as well as those for substance abuse disorders and developmental disorders are excluded unless these disorders co-occur with another diagnosable serious mental illness.
- and*
- **Disability.** In order to meet the criteria for disability, the recipient must exhibit emotional, cognitive or behavioral functioning, which is impaired, as a result of mental illness. This impairment must substantially interfere with role, educational, and social functioning as indicated by a score within levels four (4) or five (5) on the Child and Adolescent Level of Care Utilization System (CALOCUS) and can be verified by the Bureau.

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

*and*

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

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

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

**Exclusionary Criteria**

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

**Discharge Criteria**

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

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

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

## **SERVICES**

### **Service Delivery**

The provider shall provide all mandatory services. Mandatory services shall not be subcontracted. The provider may choose to provide the optional services, either in house or through a subcontractor. If the provider chooses to subcontract the optional services, the subcontractor must meet all provider participation requirements including, but not limited to, licensing and certification requirements. The provider shall prevent a duplication of services by ensuring that services requested and offered to a recipient are not available and offered by a non-MHR provider. Prior to submitting a request for services, the provider shall gather necessary information from non-MHR providers including, but not limited to, residential programs, case management services, counseling centers, school based programs, and assertive community treatment teams to prevent such a duplication. To prevent duplication of services, a copy of the OCS, OJJ, Office of Addictive Disorders (OAD), Office of Citizens with Developmental Disorders (OCDD), or any other therapeutic intervention plan must be submitted to the Service Access and Authorization Unit when requesting services.

There shall be family and/or legal guardian involvement throughout the planning and delivery of services for children and youths. The agency or individual who has the decision-making authority for children and youths in state custody must request and approve the provision of services to the recipient. If applicable, the OCS or OJJ case manager or person legally authorized to consent to medical care must be involved throughout the planning and delivery of all services and the provider must document the involvement in the recipient's record.

The child or youth must be served within the context of the family and not as an isolated unit. Services shall be appropriate for the following characteristics:

- Age,
- Developmental level,
- Educational level, and
- Culture.

If a recipient/family is unable or not willing to attend a scheduled appointment, the provider shall make a reasonable effort to conduct follow-up and outreach services. This may include scheduling the appointment in the evening or on a weekend, in the recipient's home or another community location. It is a clinical decision when a reasonable effort has been made. Documentation of all attempts to contact the recipient should be entered in the recipient's record. You may use a service log marked "For File Only".



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When a recipient is discharged, a referral must be made to available community resources and documented in Mental Health Rehabilitation Services Information System (MHRIS). If telephone contact with the recipient or his/her family is not possible, the referral information must be mailed.

## **Mandatory Services**

### **Assessment and Service Planning**

#### **Service Definition**

The initial assessment and reassessment are an integrated series of diagnostic, clinical, psychosocial evaluations conducted with the recipient and his/her significant others to develop an effective, comprehensive individualized services and recovery plan (ISRP). It may also be used to determine the recipient's level of need and medical necessity.

#### **Program Requirements**

The initial assessment must be completed for all new recipients and for those with a twelve (12) month or more lapses in service. The initial assessment form must be completed within thirty (30) calendar days following the initial screening and submitted to the Bureau for approval. Under exceptional circumstances, at the discretion of the Bureau, extensions beyond the thirty (30)-day assessment period may be granted on a case-by-case basis. Requests for extensions should be thoroughly documented and directly related to the reason for the delay. (Example: a fifteen (15) day extension is being requested because the recipient was hospitalized for fifteen 15 days.)

Information in an initial assessment shall be based on current circumstances (within thirty (30) days) and face-to-face interviews with the recipient, as well as consider pertinent historical data. If the recipient is a minor, the information shall be obtained from a parent, legal guardian or other person legally authorized to consent to medical care.

With the recipient's and/or family's consent, historical data, including but not limited to past treatment records, school reports, and/or past assessments, must be requested prior to the start of the assessment. This data should be reviewed as part of a complete and accurate assessment. The recipient's record must contain documentation of all efforts to obtain this data.

A reassessment must be completed every ninety (90) calendar days after the initial assessment or as deemed necessary by the Bureau. For example, a reassessment may be required after sixty (60) calendar days if a provider is requesting a Request for Revision.

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Information in a reassessment shall be based on circumstances since the most recent authorization and a face-to-face interview with the recipient. Reassessment data must be approved by the Bureau. If the recipient is a minor, the information shall be obtained from a parent, legal guardian or other person legally authorized to consent to medical care. This data is the foundation of the recipient's ISRP.

In order to ensure an adequate and recovery/resiliency focused assessment, providers are required to utilize a variety of methods to gather assessment data. Assessments must be complete and accurate given the condition and circumstances of the recipient. To make a clinically valid assessment, additional methods to gather assessment data should include:

- A review of all prior services that the recipient has received in the past year. This may include discharge summaries, service summaries, or copies of clinical records.
- Collateral contacts (telephone, face-to-face, and/or written correspondence) with prior service providers and other systems (e.g. social services, corrections, schools, etc) who are involved with the recipient.
- Interviews with individuals who have directly observed the recipient's functioning and behaviors in his/her natural environment (home, school, work, community).

The information outlined below must be documented in the initial assessment:

- Presenting problem including source of distress, precipitating events, associated problems or symptoms and recent progressions,
- Risk assessment, including suicide risk,
- Mental status including at least:
  - Appearance, attitude and behavior,
  - Orientation to person, place, time, and date,
  - Affect and mood, and
  - Thought content/processes including:
    - Intelligence,
    - Fund of knowledge,
    - Cognitive processes,
    - Memory,
    - Insight and judgment,
    - Homicidal/Suicidal risk.
- Personal strengths, abilities and/or interests,
- Previous behavioral health services data (such as a clinical record, discharge summary, etc) including:

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- Diagnostic information,
- Treatment information (dates, locations, duration, frequency modalities, efficacy—including factors that have contributed to or inhibited previous recovery efforts), and
- Efficacy of current and previously used medications.
- Physical health history and current status including medication allergies and adverse reactions within the last year. There must be evidence of a review by a treating psychiatrist as a part of the assessment,
- Medication use profile,
- Developmental history (for recipients under the age of eighteen),
- Pertinent current and historical life situation information that establishes a recovery/resilient environment including:
  - Age,
  - Gender,
  - Employment history,
  - School/education history including current level of functioning,
  - Legal involvement, and
  - Family history,
- History of abuse (including trauma survivor issues, spousal/partner abuse, physical, psychological, sexual, emotional abuse, and whether the recipient was a victim or a perpetrator of said abuse),
- Relationship including natural support,
- Housing or living environment including where, with whom, how long, and how stable,
- Use of alcohol, tobacco, and/or other drugs,
- Current level of function in life skills,
- Individualized needs and preferences (e.g., recipient choices of location, service type, provider, and focus of services),
- Issues important to the recipient including, but not limited to:
  - Cultural background,
  - Spiritual beliefs, and
  - Sexual orientation,
- Need for and availability of social supports,
- Risk taking behaviors (e.g., unprotected sex, run away, etc.),
- Advance directives if applicable,
- Diagnostic impressions using DSM-IV(or current version), Axes I-V, and
- List of individuals interviewed including location.

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A comprehensive initial assessment includes the development of a written Integrated Summary to synthesize, evaluate, integrate, and interpret the data gathered in the assessment. The Integrated Summary section must include:

- Presenting problem(s) and/or illness(es),
- LOCUS/CALOCUS score,
- The recipient's strengths and needs,
- The recipient's preferences in services (cultural, location, etc),
- Significant features from any aspect of the assessment including mental status, risk factors, medical, medications, etc.,
- Summary of base line functioning,
- DSM IV diagnosis, Axes I-V, and
- Recommended prioritized service objectives and interventions.

The information outlined below must be documented in the reassessment:

- DSM IV diagnosis, Axes I-V;
- The results from the LOCUS/CALOCUS including specific documentation to support the overall level of care recommendation and the rating in each dimension;
- Medications, including efficacy of current and previously used medications;
- Utilization of crisis services;
- Risk assessment, including risky behavior and suicide risk;
- Current Functional Status including basic needs and mental status exam; and
- Describe:
  - The presence of a co-morbid condition(s),
  - Stressors in the natural environment,
  - Need for and availability of social supports,
  - Resiliency and recovery,
  - Engagement,
  - Treatment barriers,
  - Strengths and needs,
  - Preferences in services (cultural, location, etc), and
  - Barriers to accomplishing goals and objectives.

Reimbursement for initial assessment and reassessment includes all activities but is not limited to:

- Review of all prior services including discharge summaries, service summaries, or copies of clinical records.
- Collateral contacts (telephone, face-to-face, and/or written correspondence) with prior service providers, and other systems (e.g., social services, corrections, schools, etc).

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- Interviews to support direct observations.
- Face-to-face meeting(s) with the recipient and his/her significant others.
- Administration of the LOCUS/CALOCUS.
- All relevant documentation including service logs and assessment documents.
- Any team or internal meetings required to discuss or review assessment process and findings prior to service planning team meeting.

**Service Planning**

Service Planning is the team process of developing and/or finalizing the recipient's individualized service and recovery plan (ISRP) and Contingency Crisis and Discharge Plans, periodically reviewing progress toward the goals of the ISRP, and modifying it as indicated. The ISRP is an individualized, structured, goal-oriented schedule of services developed jointly by the recipient and treatment team. Recipients must be actively involved in the planning process and have a major role in determining the direction of their ISRP. The ISRP must identify the goals, objectives, interventions, and units of service based on the results of an assessment and agreed to by the adult or youth and his/her parent/guardian. Service planning does not include regular team meetings, staff training or supervision.

All service requests on the ISRP must be individualized to meet the recipient's needs. It is not permissible to use terms such as 'as needed' or 'PRN' to describe frequency or duration of services. The ISRP must be developed and reviewed as follows: all timeframes are calendar days and must be tracked by the date of recipient signature.

An interim ISRP must be developed as part of a recipient's initial assessment. Goals and objectives must address immediate needs identified in the recipient's initial assessment, especially health and safety issues. The initial ISRP must be completed within thirty (30) days of notice to the provider of the recipient's eligibility (refer to section 31.2 Service Access and Authorization for more detail regarding interim authorizations) and must address the recipient's needs for the first ninety (90) day authorization.

The licensed mental health professional (LMHP) along with the recipient, natural support, and the treatment team must develop the initial ISRP. ISRP updates are submitted to the Bureau every ninety (90) days as part of the reassessment, with a request for revision, or as requested by the Bureau. The community support worker may draft updates to the ISRP with the recipient and natural support. The LMHP must review and sign the final ISRP as part of the service planning team meeting as outlined below.

The ISRP must be updated to reflect changes made to services. Changes may include developing and revising goals, objectives, interventions, the discharge plan, and the crisis plan. The recipient and/or family members must sign or initial each change. Though the ISRP does not need to be resubmitted each time a change is made, a summary of the changes must be described when requesting a reauthorization.

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The ISRP must:

- Be based on the needs and desires of the recipient and focused on his/her integration and inclusion into the local community, the family, and, when appropriate, natural support systems.
- Involve the family of the recipient when applicable and permitted.
- Identify any needs beyond the scope of the MHR program.
- Specify the services that will be provided.
- Specify referrals to any services provided by other providers or community resources.
- Be provided to the recipient/family in writing.

The ISRP must be written using language that the recipient will understand. Complex words and phrases, medical terms, and abbreviations must not be used in an ISRP. The ISRP must be appropriate to the recipient's culture and age (chronological and developmental). Updated ISRPs must include an explanation of progress made toward meeting goals and objectives (i.e. met, not met, and discontinued). Failure to meet a goal or objective indicates the need for an ISRP revision.

The ISRP must include a list of prioritized needs identified in the most recent assessment as well as a list of services beyond the scope of what the agency can provide (for example, access to substance abuse treatment, physical health treatment, sexual abuse treatment, vocational rehabilitation, recreational activities, and inpatient care). The provider is responsible for coordinating all services.

The ISRP must include the following components:

- Goals
- Objectives with target dates
- Interventions
- Individualized/Recovery Focused Crisis Plan
- Discharge Plan

**Goals**

A goal is defined as a broad statement that reflects what a recipient hopes to accomplish to address a priority need. They are more general than objectives and should be targeted for completion within the authorization period. Each goal must include:

- A description of the recipient's strengths, resources, and supports,
- Specific objective(s) with target dates, and
- Specific intervention(s).

**CHAPTER 31: MENTAL HEALTH REHABILITATION****SECTION 31.1: SERVICES****PAGE(S) 39****Objectives**

Objectives are defined as the smaller more specific steps necessary to accomplish a goal and reflect the recipient's and treatment team's expectations. They must take into account the recipient's age, development, disabilities and concerns. Objectives must be developed following the principles of S-M-A-R-T, which requires objectives to be:

- Specific,
- Measurable,
- Action-oriented,
- Realistic, and
- Time limited.

Objectives that are not developed in accordance with the principles of S-M-A-R-T may result in a denied authorization request and/or sanctions following a post payment review.

Specific objectives make it clear to the recipient, family, and staff exactly what is to be done. Specific objectives allow the recipient, family and staff to determine if changes are needed to the service plan including, but not limited to, frequency of contact, service type, and effectiveness of a behavioral intervention plan. Objectives must be based on observable behaviors/skills the recipient will target for development or improvement during the authorization period. Objectives which include phrases such as "improve school behavior" or "will learn more independent living skills" are considered to be too general.

Measurable objectives allow recipients, natural supports, and staff to determine whether an objective is being accomplished. In order to establish measurable objectives, staff must gather baseline data as well as collect ongoing data while services are being provided. Data collection determines the extent to which a recipient needs to improve his/her behavior or skills as well as to determine the type of measure that will be used to verify that an objective has been achieved.

Data collection may include the use of standardized assessment tools, checklists, and observations. Measures may include improved grades (from a C to an A), an increase in the frequency of a positive behavior or skill, or the dollar amount a recipient may deposit in his/her savings account.

Action oriented objectives make it clear to the recipient, family, and staff what the recipient is expected to do, instead of what the recipient is to stop doing. Action oriented objectives are positive in nature, and give the recipient a road map for dealing with problems or issues related to his/her mental illness. Objectives that are negative such as "I will stop fighting" or "I will reduce my symptoms" do not promote positive changes and learning.

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Objectives should be based on a recipient's strengths, needs, interests, and abilities. Developing realistic objectives involves building on strengths while developing new skills, abilities, interests, and personal insight. The team members must work closely with recipients and family to establish objectives that are reflective of the recipient's abilities.

Objectives must include realistic target dates that do not exceed the authorization period. For planning purposes, target dates are used to identify for the recipient, family, and staff the amount of time that the team expects it will take to accomplish each objective. If an objective is not accomplished by the established target dates, the team may adjust the time-period or modify the objective.

**Interventions**

Interventions are methods that the provider uses to help a recipient achieve his/her objectives. LMHP staff is responsible for ensuring that staff members are competent to provide the interventions detailed in the ISRP. Interventions should be well defined for all team members, and relate to an objective. Interventions that include teaching skills should be very specific and should include the teaching methods (modeling, role-play, etc.). Interventions must be active in nature, and do not include "watchful oversight." The recipient, family, natural support, and staff should be clear as to how the objective will be addressed.

Therapeutic interventions such as cognitive-behavioral therapy (CBT) and behavior modification should be documented in the intervention. Evidence based strategies should be used, if appropriate. Interventions that are general such as "assist", "develop", "teach" without specific details may result in a denied authorization request and/or sanctions following a post payment review.

**NOTE:** For a list of evidenced based strategies, visit the Substance Abuse and Mental Health Services Administration (SAMHSA) website at [www.samhsa.gov](http://www.samhsa.gov) or visit the MHR website, [www.mhrsla.org](http://www.mhrsla.org), for a link to resources.

**Individualized/Recovery Focused Crisis Plan**

The crisis plan must be developed as part of the initial assessment and updated with the ISRP. The recipient, family, and staff develop and update the crisis plan based on an ongoing assessment of the recipient's risk, skills, and natural support. The recipient must have a copy of the current plan. The plan should be posted in a common area of the home near a telephone. MHR staff must ensure that the recipient and his/her natural support understand all aspects of the plan. This may include skills training with the recipient as well as natural supports who will be involved in the implementation of the plan.



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Providers must not list 911 as the first and only contact telephone number. Instead, the provider must educate the recipient regarding circumstances that will necessitate calling 911 for emergency assistance. Current contact telephone numbers must be maintained on the crisis plan. Evidenced based methods such as the Wellness Recovery Action Plan (WRAP) should be used if appropriate.

When an agency agrees to provide services to a recipient at Level five (5), it is done with the understanding that it is imperative that the agency develop a safety/crisis plan that will provide for the safety of the recipient twenty four (24) hours a day. Those agencies who do not have the expertise or resources available to meet this requirement should **not** agree to provide services to recipients who score a Level five (5) on the LOCUS/CALOCUS. Services for Level five (5) recipients must include comprehensive clinical services, support services, crisis stabilization services, and prevention services.

The crisis plan must:

- Describe what constitutes a crisis for the recipient. The team may consider events that caused the need for hospitalization in the past and caused significant distress for this recipient. Staff should ask the recipient to describe events he/she would consider a crisis.
- Describe events/situations that may be precipitants to a crisis. The team may describe behaviors/situations that have happened just before (triggered) crisis in the past and list observable behaviors which, for this recipient, mean that things have worsened and may be close to becoming a crisis (warning signs).
- Describe what action (s) can be taken by the recipient and/or natural supports to address the crisis which may include specific behavior strategies and environmental safeguards. If there are currently no natural supports available, the team should consider including goal (s) on the ISRP to focus on developing natural supports.
- Describe what action (s) can be taken by staff based on the needs of the recipient to ensure primary health and safety needs are met. Staff responding to a crisis must have a copy of the current plan and must receive training regarding the intervention methods detailed in the plan.
- Include the name, address, telephone number of supporters the recipient wishes to help them when at risk of entering or in a crisis. It is important that the list of supporters is current with accurate information including name/contact number/assigned task of each supporter.

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- Include the name, title, and contact information for the primary community support worker and other agency support staff including the LMHP and the psychiatric director. Staff shall ensure that agency contact information is clear, accurate, and up-to-date.
- Include other instructions from the recipient as well as information that he/she would want others to know/follow in times of crisis. The plan should include pertinent information from the recipient's advance directive.

**Discharge Plans**

Discharge planning is the formal process that leads to the development of an ongoing individualized plan of care that meets the assessed needs of the recipient upon discharge from service. The first discharge plan is developed during the interim authorization. The plan is updated as needed. The updated plan is submitted with each quarterly authorization request or at the request of the Bureau. MHR staff, particularly the community support worker, is responsible for coordinating and implementing the plan. Any specific recipient circumstances (e.g., housing, job, school) that must be in place prior to discharge or transition. The plan should address the following areas:

- Physical health
- Safety/Emergency
- Use of medication
- Home management (cleaning, cooking, maintenance)
- Budgeting
- Transportation and travel
- Recreation and leisure
- Social and personal skills

A written draft of the proposed ISRP may be developed outside of the service planning team meeting with final changes made during the meeting. Effective service planning must include representation from all systems of support and care in which the recipient is engaged. The service planning team at a minimum must be comprised of the:

- Recipient,
- Recipient's primary LMHP,
- Recipient's primary community support worker,
- Recipient's family or caretaker(s), if the recipient is a youth, and
- OJJ or OCS caseworker, if the recipient is in their custody. If the OJJ or OCS caseworker is not physically present at the service planning team meeting, a good faith effort shall be made to schedule a teleconference or videoconference during the service planning team meeting or to arrange the meeting at the OCS or OJJ office.

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It is desirable for the following additional team members to participate in service planning as applicable:

- All staff providing direct services to the recipient and his/her family,
- Prescribing psychiatrist if other than the MHR contracted or employed psychiatrist, and
- Representatives from other systems of care or services in which the recipient is engaged including but not limited to:
  - Schools,
  - Juvenile/adult corrections or justice related,
  - Acute care facilities,
  - Child welfare/social services,
  - Other service/community providers.

The provider must have an original completed, dated sign-in team meeting document, as well, as evidence of invitations extended to the meeting such as copies of letters, emails or service logs.

Each ISRP must be reviewed, signed and dated by the:

- Recipient,
- Recipient's primary LMHP,
- Recipient's primary community support worker,
- Recipient's family or care taker(s), if the recipient is a youth

OJJ or OCS representative if the recipient is in their custody, and the psychiatrist. In the event the psychiatrist is not present at the meeting during review of the ISRP, the MHR or Non-MHR psychiatrist must review the ISRP within ten (10) calendar days following the meeting and sign a certification statement. If the recipient has selected a non-MHR psychiatrist, the MHR psychiatrist must complete a service log to document consultation with the non-MHR psychiatrist prior to submitting the initial ISRP and at least quarterly thereafter. Documentation of all required invitation and participation of service planning stakeholders as delineated above must be maintained.

**Staffing Requirements**

The psychiatrist shall:

- Conduct a face-to-face interview with the recipient at initial assessment.
- Review and sign the Medical History Questionnaire section of the initial assessment during a face-to-face contact.
- Review, sign and date the ISRP at initial assessment and reassessment.
- Review and sign the Electronic Clinical Data Inquiry (e-CDI) screen print. If no data is available, the screen print must also be signed.

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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 OMH 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 MHRSIS 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 MHRSIS. Providers shall follow current MHRSIS policies regarding entering data.

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**Service Authorization Periods**

- Thirty (30) days for initial assessment
- Up to ninety (90) days for the reassessment

**Community Support****Service Definition**

Community support is the foundation of the recovery-oriented ISRP and is essential to all recipients. Its goal is to increase and maintain competence in normal life activities and gain the skills necessary to allow them to remain in or return to their own natural environment. It provides the necessary services to assist the recipient in achieving and maintaining rehabilitative, resiliency and recovery goals related to education, work, housing, mental health treatment, financial and social supports and other support needs. Community support includes crisis intervention, coordination of MHR and non-MHR services, and individual skills training.

Specific goals of the service are:

- To achieve the restoration, reinforcement, and enhancement of skills and/or knowledge necessary for the recipient to achieve maximum reduction of his/her psychiatric symptoms.
- To minimize the effect of mental illness.
- To maximize the recipient's strengths with regard to the mental illness.
- To increase the level of the recipient's age-appropriate behavior.
- To increase the recipient's independent functioning to an appropriate level.
- To enhance social skills.
- To increase adaptive behaviors in family, peer relations, school and community settings.
- To maximize the skills to link and engage with other community services including natural supports and resources.
- To apply decision-making methods in a variety of skill building applications.

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**Program Requirements**

Community support is an individualized service and is not billable if delivered in a group setting. Each recipient shall have one designated provider who will serve as the “mental healthcare home” for the recipient and family. The recipient will choose a designated community support worker who is the primary point of contact. While the community support worker provides the majority of community support activities, he/she may not be the exclusive provider.

The community support worker acts as the first responder (triage, support and intervention) for recipients in crisis, which may include face-to-face contact. When he/she is unavailable, there must be a backup worker. The name of the backup worker and how to contact him/her must be provided in writing to the recipient and the family (if the recipient is a minor) or care giver. If the emergency is of a clinical nature, the MHP/MHS must consult with the LMHP or psychiatric director if the recipient’s circumstances are beyond his/her ability to ensure the safety of the recipient and others.

The community support worker assures access to and coordination of MHR and non-MHR services, subject to the face-to-face and community ratios, through the following activities:

- Establishing/maintaining interagency coordination, which may include education, Louisiana Rehabilitation Services (LRS), OAD, OCDD, OCS and OJJ.  
**Example:** A youth who is at risk of entering the juvenile justice system may need coordination with the Family In Need of Supervision (FINS) program.
- Engaging in collateral consultation with other service systems or individuals (family members, significant others and professionals) who are actively involved in the recipient’s care, ensuring a comprehensive set of services and preventing duplication.
- Promoting active recipient involvement by:
  - Contacting the recipient face-to-face and by telephone.
  - Providing aggressive outreach if recipient participates less than specified in the ISRP. Aggressive outreach includes making every reasonable effort to provide continuing care, which may include enlisting the help of natural supports. Aggressive outreach should continue until the recipient resumes services or is successfully referred to another service provider.
- Monitoring the recipient’s self-management of symptoms.
- Drafting updates to the ISRP with the recipient and natural supports. The LMHP must review and sign the final ISRP as part of the service planning team meeting as outlined below.

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**NOTE:** Services that meet the service definition of Medication Management are excluded.

The community support worker provides individual skills training, which must be based on a curriculum or other published material that represents nationally recognized best practices. Targeted areas of skills training typically include:

- Socialization skills.
  - Communication,
  - Interpersonal relationships, including those with peers, family, and authority figures,
  - Problem solving/conflict resolution,
  - Management of sensory input and stress.
- Natural support system development that includes self-directed engagement in community social activities and the development of a social plan.
- Adaptation skills.
  - Identification of behaviors that interfere with performance,
  - Implementation of interventions to alleviate problem behavior, including coping with symptoms of mental illness that affect the person's ability to successfully work and/or attend school,
  - Development of the ability to follow directions and carry out assignments,
  - Acquisition of appropriate school habits,
  - Adaptation to community, environmental and/or family circumstances and realities,
  - Education in mental health/mental illness,
  - Development of individual day-to-day skills necessary for the recipient to comply with taking prescribed medications (services that meet the definition of medication management should be provided by staff credentialed to offer that service),
  - Development of day-to-day skills necessary for the recipient to identify, monitor, and self-manage his/her psychiatric symptoms, which interfere with their daily living, financial management, personal development, school or work performance.
- Developmental issues.
  - Physical changes,
  - Emotional changes, and
  - Sexuality.
- Daily living skills.
  - Age and developmentally appropriate daily and community living skills,
  - Personal hygiene and grooming,
  - Nutritional services,
  - Food planning, grocery shopping, cooking, and eating,

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- Household maintenance, including housecleaning and laundry,
- Money management and budgeting, and
- Shopping for daily-living necessities.
- Community awareness and current events.
- Identification and use of social and recreational skills.
- Use of available transportation.
- Personal responsibility,
- Work readiness activities (excepting skills related to a specific vocation, trade, or practice) including:
  - Work related social and communication skills;
  - Work related personal hygiene and dress;
  - Work related time management; and
  - Other related skills preparing the recipient to be employable.

**Place of Service and Frequency of Contact**

Community support is primarily a face-to-face service and is primarily provided in the home or other community setting. Sixty (60) percent of the contacts provided during an authorization period must be face to face. No less than eighty (80) percent of those face-to-face contacts must be provided in the home or community. Contacts occur during times and locations best suiting the recipient's needs including after school, after work, evenings and weekend hours and include the following settings:

- Recipient's home;
- School;
- Other community environment which allows for privacy and confidentiality and is appropriate to the age, level of need, and structure needed for the recipients; or
- The MHR facility.

**Staffing Requirements**

Community Support may be provided by an:

- LMHP
- MHP or MHS under the supervision of an LMHP

Caseloads shall be effectively managed based on the recipient's needs and shall not exceed 1:30 (one (1) community support worker for each thirty (30) recipients receiving community support services).



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**Service Authorization Periods**

- Interim – thirty (30) days
- Initial – ninety (90) days
- Subsequent – ninety (90) days

**Group Counseling****Service Definition**

Group counseling is a face-to-face interaction between two to eight recipients. It is a therapeutic service utilizing specific interventions, which must be documented in the recipient's ISRP. Evidenced based strategies should be used when applicable. Sessions are typically limited to one (1) hour.

**Clinical Exclusions**

The provider shall not admit any recipient who poses a documented health and safety risk to himself/herself, to other recipients, or for whom the provider cannot provide the necessary care.

**Program Requirements**

The service is directed to the goals on the approved ISRP. Sessions are scheduled to provide effective treatment consistent with the ISRPs of the group members. It should be available at times most convenient to the recipient/family needs and requests, including evenings and weekends. Participants must be of similar age, developmental level and psychosocial need. For children, if age difference exceeds three (3) years, the provider must document the basis for inclusion in the group in the recipient's record (service log or progress note).

Group counseling will be limited to the following topical areas:

- Anger management.
- Behavior management.
- Grief/loss.
- Trauma (sexual/physical/verbal).
- Sexual offenders.
- General symptom management skills, including:
  - Identification and management of symptoms of mental illness;
  - Compliance with physician's medication orders; and
  - Reduction and alternatives to aggression.

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Topics and interventions (including those conducted in multi-family groups) must be consistent with the above topics and be directed exclusively to goals/objectives on the recipient's ISRP. Parenting skills training related to these topics may also be included.

**NOTE:** Collateral contacts or other non-face-to-face contacts are not billable under this service code.

**Place of Service**

This service may be provided at an MHR facility or off-site service delivery location as defined in Section 31.4. However, it 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.

**Staffing Requirements**

Group size may not exceed one (1) staff member to eight (8) group participants. A staff member must be present at all times during the group session. If a group is co-facilitated by more than one (1) staff member, only one (1) staff member can bill for each recipient.

The following individuals may provide Group Counseling:

- An LMHP
- An MHP under the supervision of an LMHP

**Service Authorization Periods and Service Limits**

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

**Individual Intervention****Service Definition**

Individual intervention is an interaction between the counselor/therapist and the recipient. It is a face-to-face structured service based on a range of professional therapeutic strategies, which must be documented in the recipient's ISRP. Evidenced based strategies should be used when applicable. Sessions are typically limited to one hour. For contacts lasting longer than one hour, the service log must include the reason for the extended session.

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This service is provided to ameliorate the psychosocial barriers that impede the development or enhancement of skills necessary to function in the community.

Individual Intervention is relevant to the recipient's needs and relate directly to the individualized goals and objectives specified in the ISRP.

These services are based on psychological treatment principles. Specifically, these include counseling and therapy services that:

- Maximize strengths;
- Reduce behavioral problems;
- Change behavior;
- Improve interpersonal skills;
- Explore and clarify values; and
- Facilitate interpersonal growth and change.

**Place of Service**

This service may be provided in the recipient's home, an MHR facility, school, or other off-site service delivery location. It should be available at times most convenient to the recipient including evenings and weekends.

**NOTE:** Collateral contacts or telephone contacts are not billable under this service code.

**Staffing Requirements**

The following individuals may provide Individual Intervention:

- An LMHP
- An MHP under the supervision of an LMHP

**Service Authorization Periods**

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

## **Medication Management**

### **Service Definition**

Medication management is provided to:

- Assess,
- Monitor a recipient's status in relation to treatment with medication,
- Instruct the recipient, family, significant others or caregivers of the expected effects of therapeutic doses of medications, or
- Administer prescribed medication when ordered by the psychiatrist (or other prescriber as allowed under applicable law) as part of an ISRP that is inclusive of additional rehabilitation services and supports.

### **Program Requirements**

All activities of medication management must be provided face-to-face and at a minimum shall be available to recipients during normal operating hours. It cannot be provided in a group setting. Necessary collateral or telephone contacts are included in the reimbursement for this service and must not be billed.

This service includes four primary activities:

- Initial Medication Assessment—the initial assessment of the need for, type and dosage of medications directed toward maximizing a recipient's functioning and reducing symptoms. This assessment is minimally inclusive of:
  - Medical history-general health.
  - Review of past medication history.
  - Other prescriptions including non-psychotropics.
  - Untoward side effects and contraindications.
  - History of compliance.
  - Efficacy of past/current medication prescribed to treat a behavioral disorder.
  - Review of abuse history (prescription/non-prescribed).
  - Medication type and dosage ordered as a result of the assessment.
- Medication administration—the administration of therapeutic doses of medication for the treatment of mental disorders that have been prescribed and are monitored by a psychiatrist (or other prescriber as allowed under applicable state law) and indicated in the recipient's ISRP.

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“Administration” shall be interpreted consistent with applicable state law but minimally is inclusive of injectables (shots), direct dosing of oral medications, and repackaging of oral medication into “pill boxes” or daily dosage boxes when pills are placed in the boxes directly by staff credentialed to administer medications.

- Medication monitoring—the ongoing review of symptoms, side effects, effectiveness, applicable lab or other measures, compliance, and prescription renewal and adjustment of psychotropic medications.
- Medication education—involves the instruction of the recipient, family, significant others, and care givers on the expected effects of prescribed medication.

Medication Education may include but is not limited to:

- Proper use and storage of medications.
- Rationale for the medication.
- Possible side effects, including impact on pregnancy, age, sex, or disability.
- Early warning signs of relapse and signs of non-adherence and noncompliance with medication prescription.
- Circumstance/symptoms requiring contact with a medical professional.
- Use/interactions with other substances (prescribed/non-prescribed).
- Instruction on the proper self-administration of medications.

If an individual is in crisis and the prescribing practitioner changes the medication or dosage, medication education must be provided within one (1) business day.

The following frequency of service requirements apply to all recipients on psychotropic medications for which the provider is the primary prescribing and monitoring entity:

- Initial medication assessment – completed and documented in the clinical record during the interim authorization period, not to exceed thirty (30) days from the date eligibility was determined.
- Monitoring – provided as justified by recipient need but in no case less frequently than once every ninety (90)-calendar days.
- Medication administration – frequency as required by prescription, orders and the ISRP.

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- Medication education – as required in the ISRP, but minimally must be documented in the clinical record at the time of any change in medication including dosage or type.

The administration of all medications, medication errors, and adverse drug reactions must be documented. Within thirty (30) days of the initial assessment and ninety (90) days thereafter, a physician must conduct an evaluation. There must be a process for immediately notifying the attending physician of drug reactions, medication errors, and /or other related problems.

**Storage of Medications**

Only staff authorized to administer or supervise self-administration of medication shall have access to medications. All medications must be handled in accordance with applicable state and federal law including:

- Labeling all medications properly and storing them under lock and key.
- Storing medications for external use separately from internal and injectable medications.
- Storing disinfectants separately from all medications.
- Storing medications under proper conditions of sanitation, temperature, light, moisture and ventilation.
- Removing outdated medications and disposing of them.
- Disposing of needles in accordance with the established Occupational Safety and Health Administration (OSHA) policy for handling medical waste.

The telephone number of existing poison control centers, ambulance and other emergency medical centers should be readily accessible to the staff and recipient.

**Staffing Requirements**

Medication Management is limited to licensed medical practitioners operating within their scope of practice as allowed under the applicable state law(s). In addition, psychiatrists (M.D. or D.O.) shall be board eligible (as defined by the Bureau) or board certified. Advanced Practice Registered Nurse (APRN)/Clinical Nurse Specialist (CNS) or a Nurse Practitioner (NP) must operate under an approved collaborative practice agreement with a board certified or board eligible psychiatrist. The Louisiana State Board of Nursing must approve the collaborative practice agreement prior to delivering services.

Credentials allowable for core activities within medication management are as follows:

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- **Initial Medication Assessment**
  - Psychiatrist
  - APRN/CNS or NP certified in psychiatry
- **Medication Administration**
  - Psychiatrist
  - APRN/CNS or NP certified in psychiatry
  - Registered Nurse (RN)
  - Licensed Practical Nurse (LPN)
- **Medication Monitoring**
  - Psychiatrist
  - APRN/CNS or NP certified in psychiatry
  - Registered Nurse (RN)
- **Medication Education**
  - Psychiatrist
  - APRN/CNS or NP certified in psychiatry
  - Registered Nurse (RN)

**Service Specific Documentation Requirements**

In addition to documentation required for each contact, the following specific documentation must be present in recipients' records for whom Medication Management is provided:

- Medication Administration Record (MAR)
- Medication Errors and Reporting Form
- Adverse Event Drug Reporting Form (pharmacy or drug related)
- e-CDI printout
- Medication Consent
- Physician's Orders
- Lab results (as applicable)
- Medication education documentation (for each prescribed drug when initially prescribed)

**Place of Service**

This service may be provided at the MHR office, an off-site service delivery location or in a recipient's natural environment (schools, home, etc) appropriate to the recipient's needs and circumstances and in compliance with privacy and confidentiality requirements.

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- Interim – thirty (30) days
- Initial – ninety (90) days
- Reassessment – up to ninety (90) days

**Parent/Family Intervention (Counseling)****Service Definition**

Parent/Family Intervention (Counseling) is a face-to-face therapeutic intervention involving the recipient and one or more family members. The primary goal is to help the recipient and family improve their overall functioning in the home, school, work and community settings. This goal is accomplished by helping the recipient and family increase effective coping mechanisms, healthy communication strategies, constructive problem-solving skills and increased insight into the nature of the recipient's difficulties and the impact on the family. 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. These services are intended to be time limited with services reduced and discontinued as the family functions more effectively.

Parent/Family Intervention includes regularly scheduled face-to-face interventions, with the recipient and family designed to improve family functions. Specific interventions may include:

- Assisting the family with developing and maintaining appropriate structure within the home.
- Assisting the family with developing increased understanding of the recipient's symptoms and problematic behaviors and developing effective strategies to address these issues, and encouraging emphasis on building upon the recipient and family's strengths.
- Facilitating the family's ability to effectively manage, teach, and positively reinforce the recipient's strengths.
- Facilitating effective communication and problem solving between the recipient and family members.



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The service should be available at times of operation most convenient to the recipient/family needs and requests, including evenings and weekends.

The recipient must be present for counseling sessions except where therapeutically contraindicated. Reasons must be documented in service logs for each meeting in which the recipient is not present. Necessary collateral or telephone contacts are included in the reimbursement for this service and are not billable.

**Place of Service**

Services may be provided at the MHR office, an off-site service delivery location, or in a recipient's natural environment (school, home, etc.) as appropriate to recipient needs and circumstances and in compliance with privacy and confidential requirements.

**Staffing Requirements**

The following individuals may provide Parent/Family Intervention (Counseling):

- An LMHP
- An MHP under the supervision of an LMHP

**Service Authorization Periods**

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

**Psychosocial Skills Training – Group (Youth)****Service Definition**

Psychosocial Skills Training – Group (Youth) is a face-to-face therapeutic, rehabilitative, skill building service for children/youth to increase and maintain competence in normal life activities and gain the skills necessary to allow them to remain in or return to their communities. It is an organized service based on models incorporating psychosocial interventions. The goals of the service include:

- To achieve the restoration, reinforcement, and enhancement of skills and/or knowledge necessary for the recipient to achieve maximum reduction of his/her psychiatric symptoms.

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- To minimize the effect of mental illness.
- To maximize the recipient's strengths.
- To increase the level of the recipient's age-appropriate behavior.
- To increase the recipient's independent functioning to an appropriate level.
- To enhance pro-social skills.
- To increase adaptive behaviors with family and peers and in school and community settings.

**Clinical Exclusions**

The provider shall not admit any recipient who poses a documented health and safety risk to himself/herself, to other recipients or for whom the provider cannot provide the necessary care.

**Program Requirements**

Psychosocial Skills Training has a structured curriculum that is adapted to the recipient's needs and teaches skills necessary to succeed in his/her environment. The curriculum must be nationally recognized best practice standards and be age and developmentally appropriate and culturally relevant.

Participants must be of similar age, developmental level and psychosocial need. If age difference exceeds (3) three years, the basis for inclusion in the group must be documented.

Training material must include activities that will allow the recipient to practice the skill(s) taught during the group session and natural settings. This will allow the recipient to further develop and integrate the skill.

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.

The curriculum is designed to improve or maintain the recipient's ability to function in normal social roles and should include but not be limited to:

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## Socialization skills

- Communication,
- Interpersonal relationships, including those with peers, family, and authority figures,
- Problem solving/conflict resolution,
- Management of sensory input and stress,
- Natural support system development,
- Self-directed engagement in community social activities (development of a social-recreational plan for the recipient), and
- Decision-making.

## Adaptation skills

- Identification of behaviors that interfere with performance,
- Development of interventions to alleviate problem behavior, including coping with symptoms of mental illness that affect the person's ability to successfully work and/or attend school,
- Development of capacity to follow directions and carry out assignments,
- Acquisition of appropriate school habits, and
- Adaptation to community, environmental and/or family circumstances and realities.

## 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, personal development, and community integration (services that meet the definition of medication management should be provided by staff credentialed to offer that service).
- Developing skills necessary for the recipient to comply with prescribed medications.
  
- Developmental issues including:
  - Physical changes,
  - Emotional changes, and
  - Sexuality.

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Daily living skills for children/youth transitioning to independent living or as otherwise needed including:

- Age and developmentally appropriate daily and community living skills,
- Nutritional services,
- Food planning, grocery shopping, cooking, and eating,
- Personal hygiene and grooming skills,
- Household maintenance, including house cleaning and laundry,
- Money management and budgeting,
- Shopping for daily-living necessities,
- Community awareness and current events,
- Identification and use of social and recreational skills,
- Use of available transportation, and
- Personal responsibility.

Work readiness activities (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.

Psychosocial Skills Training must have an ongoing process to ensure that recipients participate in the development and periodic revision of program curricula as appropriate to their age and developmental capacity. Training occurs after school and during weekend hours when this meets the recipient's needs. The staff must be present at all times during the course of the group skills training. A group recreational outing is not billable for this service.

**NOTE:** Anger management and alternatives to aggressive behavior are more appropriately addressed in Group Counseling and must not be provided as part of this service.

**Place of Service**

This service must be provided in a location, which 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 locations, if related to the ISRP, and conducted in such 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.

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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 OMH 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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The goals of PFII include but are not limited to:

- Diffusing the current crisis, evaluate its nature and intervene to reduce the likelihood of a recurrence;
- Ensuring the linkage to needed community services and resources;
- Ensuring the clinical appropriateness of services provided; and
- Improving the recipient's ability for self care (age appropriate), as well as the parent's or legal guardian's capacity to care for their children.

**Program Requirements**

To qualify for this service, the recipient must be at risk of out of home therapeutic placement due to his/her emotional/behavioral disorder or reintegrating from out of home placement and score a Level five (5) or six (6) on the CALOCUS.

Services are based on the individual's unique needs, strengths and family culture with the goal of self-sufficiency. Documentation should incorporate the child/family's strengths and weaknesses and reflect their unique culture and values. Outcomes should include evidence of a decreased reliance on the formal system of providers and an increased reliance on family resources and informal supports.

This is a team-based service and there must be evidence of team coordination and interaction with the recipient and his/her family as a single organizational unit. A recipient would normally receive services at this intensive level for a ninety (90) to one hundred eighty (180) day period, depending on medical necessity, with a period of less intensive services to follow.

Services are individually designed in partnership with the recipient and his/her family to minimize intrusion into the family and maximize the skills necessary to increase independence. Telephone contact and collateral contacts (face-to-face and telephone) are allowed subject to the overall face-to-face service ratio referenced below. The contacts must be relevant to the ISRP and appropriately documented. PFII is comprehensive and includes all other rehabilitative services except initial assessment and medication management.

If a provider does not offer PFII services, the recipient/family must be given a list of PFII providers from which to choose a provider. The PFII provider must do all service planning until the recipient is no longer in need of intensive services. The referring provider may only provide the initial assessment, reassessment and medication management. At the completion of PFII services, the recipient may choose to return to the referring provider. Since a recipient has the freedom to choose providers, he/she may choose to refuse the PFII referral. The provider should document the effort to educate the recipient and family regarding the need for the intensive services provided by PFII.

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Service parameters must encompass the following:

**Duration of Treatment**

Services normally range from ninety (90) to one hundred eighty (180) days, depending on the presenting stabilization needs of the recipient and family. Providers may request a service extension in exceptional cases. However, the vast majority of recipients served should complete this phase of treatment within the allotted time range.

**Intensity of Service**

Services typically follow a course of treatment with intensive and frequent services in the early phases of treatment. A minimum of sixteen (16) contacts must occur within the first month. For the second and third months of services, an average of ten (10) contacts per month must occur. It is the expectation that service frequency will gradually reduce over the last two (2) months. All service contacts are subject to the face-to-face and community ratios described below.

**Face-to-Face Contact and Location of Service**

The majority of the service is provided face to face with the recipient (no less than sixty (60%) percent) of contacts over the span of the authorization period) in the home or other natural setting (no less than eighty percent (80%) of contacts over the span of the authorization period). The service shall be available at times convenient to the recipient/family needs and requests, including evening and weekends.

**Team Caseload**

Each team of three staff may not exceed a caseload of twelve (12) families at any given time. Staff to family ratio takes into consideration required evening and weekend coverage, crisis service needs, and geographical coverage.

**Crisis Management**

The provider must demonstrate the presence and application of policies and procedures addressing the following:

- **Availability**

The PFII team must be available for 24/7 telephone response and mobile outreach response to the recipient's home, school, etc., as needed. Coordination of care, resources and supports must be provided for each crisis episode.

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- **Planning and Management**

Comprehensive crisis protocols, including triage for psychiatric hospitalization must be developed, implemented and modified as needed. A crisis needs assessment with the participation of the family, must be completed for all recipients and families. The written crisis plan must clearly define intervention steps, incorporate natural supports and must not rely exclusively on professional resources. The plan must be filed in each recipient record and be re-evaluated and modified with each crisis that occurs.

**Family Involvement**

Services are family-driven, and they are an equal partner in all aspects of the service delivery. This includes involving the recipient/parents in strength based treatment planning. It also includes the recipient/parents involvement in the service planning meetings and signatures on the ISRP.

**Team Case Coordination**

There must be documentation of team coordination on each case at least once per week. This is covered under the PFII fee and is not a separate billable service. A structured weekly time should be set aside for team case coordination and review. All changes in the ISRP must be documented.

The team approach should incorporate flexible services and a capacity to address concrete therapeutic and environmental issues in order to stabilize the family situation as soon as possible. The best practice of such an approach should allow the child and family to view the services as delivered by a single organizational unit or team.

**Comprehensive Mix of Services**

PFII includes a comprehensive set of services designed to meet the mental health needs of the recipient and family. Services must be uniquely matched to each individual's presenting needs. Services shall include at a minimum:

- Crisis management,
- Intensive care coordination,
- Identification of needed community resources,
- Linkage to such resources,
- Follow-up to determine adequacy and appropriateness of resources,
- Individual and family counseling/therapy,
- Skills training, including all skills training delineated in the Community Support service description,
- Behavioral management,



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- Development of behavior management plans,
- Training of behavior management skills, and
- Monitoring, updating and adapting behavior management plan.

**System Collaboration**

Services for the recipient must address coordination and collaboration with family and significant others, and with other professional systems of care, including but not limited to education, OAD, OCDD, OJJ and OCS when appropriate.

The provider must take a lead in facilitating collaborative meetings, which include the recipient and family, in the various environments where the formal and informal supports are located.

The development of working relationships with other systems of service (i.e., schools, OJJ and OCS) may include written agreements such as memorandums of understanding, referral networks, etc. Such tools demonstrate the provider's capability and practice of providing services in the various related environments, including but not limited to homes (birth, relatives, adopted, foster), schools, temporary holding facilities, homeless shelters, etc.

Any requests for prior authorization of services for recipients involved in other systems of care shall include a copy of the treatment plan developed by that entity. This will ensure a full range of needed services are provided and prevent duplication of effort.

**Staffing Requirements**

PFII is provided by a team including the recipient, his/her family, significant others and a minimum of the following provider staff in each team (*total of three (3) staff per team*):

- One (1) full time team leader who is an LMHP with a minimum of three (3) years experience working with children, youths and their families; and
- Two (2) additional full time staff who must be one of the following:
  - An LMHP;
  - An MHP; or
  - An MHS.

No more than one staff member per team may be an MHS. No more than thirty three percent (33%) of contacts per authorization period may be provided by an MHS. Staff assigned to a PFII team must be exclusive to this team and provide no other services.

**CHAPTER 31: MENTAL HEALTH REHABILITATION****SECTION 31.1: SERVICES****PAGE(S) 39****Service Authorization Periods**

- Interim – None
- Initial – up to ninety (90) days (review and/or authorization may be more frequent)
- Reassessment – up to ninety (90) days (review and/or authorization may be more frequent)

**Psychosocial Skills Training – Group (Adult)****Service Definition**

Psychosocial Skills Training (PSR) - Group (Adult) is a face-to-face therapeutic program based on a psychosocial rehabilitation philosophy that assists persons with significant psychiatric disabilities to build the skills necessary to live successfully in the natural environments they choose.

This service should achieve the following outcomes:

- Enable the recipient to become a productive member of society, earn a wage, and live as independently as possible, thereby, reducing the recipient's dependency on state and/or federally funded programs.
- Achieve the restoration, reinforcement, and enhancement of skills and/or knowledge necessary for the recipient to achieve maximum reduction of his/her psychiatric symptoms.
- Minimize the effect of mental illness.
- Maximize the recipient's strengths.

**Clinical Exclusions**

The provider shall not admit any recipient who poses a documented health and safety risk to himself/herself, to other recipients, or for whom the provider cannot provide the necessary care.

**Program Requirements**

A Psychosocial Skills Training program must be open and available for recipient participation no less than twenty-five (25) hours a week, and no less than five (5) hours per day. The service duration shall be based on individual need and as authorized on the recipient's ISRP. Sessions must be offered at times to meet the recipient's needs, including evenings and weekends.

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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.

Psychosocial Skills Training teaches skills necessary for the recipient to succeed in his/her environment including but not limited to:

- Daily and community living skills:
  - Nutritional services,
  - Food planning, grocery shopping, cooking, and eating,
  - Household maintenance, including house cleaning and laundry,
  - Money management and budgeting,
  - Shopping for daily-living necessities,
  - Community awareness and current events,
  - Identification and use of social and recreational skills,
  - Use of available transportation, and
  - Personal responsibility.
- Socialization skills:
  - Communication,
  - Interpersonal relationships, including those with roommate(s) and neighbors,
  - Problem solving/conflict resolution,
  - Management of sensory input and stress,
  - Natural support system development, and
  - Self-directed engagement in community social activities (development of a social-recreational plan for the recipient).
  - Decision-making skills.
- Adaptation skills:
  - Identification of behaviors that interfere with performance;
  - Development of interventions to alleviate problem behavior, including coping with symptoms of mental illness that affect the person's ability to successfully work and/or attend school;
  - Development of capacity to follow directions and carry out assignments; and
  - Acquisition of appropriate work habits.
- Development of leisure time interests and skills.
- Symptom management skills – focusing on day-to-day management of symptoms. (Technical medication training should be provided under the medication management service).

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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) OMH 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 OMH within thirty (30) calendar days of the notification.

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For more information regarding the CPRP certification process and exam, visit the USPRA website at [www.USPRA.org](http://www.USPRA.org).

The following individuals may provide psychosocial skills building (group):

- An LMHP or
- An MHP or MHS under the supervision of an LMHP.

The program must have a minimum of one (1) direct service staff for eight (8) recipients at all times of active program participation.

Group size may not exceed fifteen (15) recipients for any single skill building activity.

All staff providing direct services must have completed:

- The associated population-specific orientation, and
- Orientation to the psychosocial rehabilitation model used in the program.

**Service Authorization Periods**

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

A recipient would normally participate in Psychosocial Skills Training Group (Adult) for six (6) to eighteen (18) months.

**CHAPTER 31: MENTAL HEALTH REHABILITATION****SECTION 31.2: SERVICE ACCESS/AUTHORIZATION PAGE(S) 11****SERVICE ACCESS AND AUTHORIZATION**

The Bureau must prior authorize all requests for services to ensure that the medical necessity criteria are met. Services provided without prior authorization will not be reimbursed. Prior Authorization is a function performed through Service Access and Authorization (SAA). Requests for authorization are subject to review by the medical review psychiatrist. The review process may include a medical review conference. This conference is a face-to-face or telephone meeting with a recipient's psychiatrist for the purpose of reviewing clinical aspects of a recipient's care following an eligibility or reauthorization request.

Following the interim authorization period, ongoing services may be approved for up to ninety (90) days beginning with the service authorization date. Requests for reauthorization should be submitted fourteen (14) days prior to the expiration of the current authorization to avoid lapse in services and to assure timely processing of requests. All information sent to the SAA unit is date stamped and logged into Utilization, Tracking, Oversight, and Prior Authorization system (UTOPiA) the day it is received. If information is received after 3:00 pm, it is stamped and logged into UTOPIA the following business day.

Providers and recipients will receive written notification of approved, partially denied, and/or denied requests. A request for additional information will be sent to providers if required information is missing (such as Social Security number, address, signature page, etc.). The SAA staff will contact the provider for this information. The contact will be documented as a request for more information. If the additional information is not received by the fourteenth (14<sup>th</sup>) calendar day after the receipt of the original request, the request will be denied.

Program eligibility is based on medical necessity criteria outlined on the screening form. Other factors including, but not limited to, effectiveness of interventions, recipient and family participation, and length of stay will be taken into consideration when the SAA unit reviews requests for authorization. Initial and reassessment activities include the rating of the LOCUS or CALOCUS, which are used to determine the recipient's level of care. If a recipient needs additional services during the authorization period, providers must submit a request for revision packet. The request must include a new LOCUS or CALOCUS rating as well as other documentation detailed below. LOCUS/CALOCUS ratings and the Client Data Sheet must be entered into MHRISIS and a data information file must be sent prior to submitting a request for authorization.

If it is determined at any point during the SAA process that the recipient does not qualify for services, the provider shall refer the recipient to his/her primary care physician, CMHC or other outpatient mental health clinic or to the appropriate medically necessary services with copies of all available medical and social information. The referral must be documented in MHRISIS.

**CHAPTER 31: MENTAL HEALTH REHABILITATION****SECTION 31.2: SERVICE ACCESS/AUTHORIZATION PAGE(S) 11**

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 225-922-0006.

**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 OMH. 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 MHRIS 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 MHRIS to the provider. Recipients are mailed approval letters.

**CHAPTER 31: MENTAL HEALTH REHABILITATION****SECTION 31.2: SERVICE ACCESS/AUTHORIZATION PAGE(S) 11****Denial for Eligibility**

An eligibility request may be denied for one or more of the reasons listed in the MHR denial codes. The medical review psychiatrist may evaluate denied requests. The denial notice will include the recipient's appeal rights. If the request is denied, the interim authorization will not be issued, including the unit for the initial assessment. The denial letter is mailed to the recipient and faxed to the provider.

**Phase Three (3): Developing the Initial ISRP**

During the interim authorization period, the provider will offer basic services including crisis intervention while developing the initial ISRP. The LMHP is responsible for preparing and submitting the ISRP. This plan should address the needs identified during the eligibility screen and the initial assessment. The plan should be recovery focused and written in language the recipient understands and that is consistent with his/her strengths and needs. The focus of the plan is recovery. Refer to Section 31.1 for details regarding the development of ISRPs.

The initial ISRP is submitted to the SAA unit and is reviewed according to authorization criteria that may include, but is not limited to, the following:

- The recipient/family participated in defining recovery goals and objectives which are documented in the plan as indicated by; recipient/family signature (all children six (6) and older must sign plan);
- Requested services are age, cognitively, culturally or developmentally appropriate;
- Evidence based – best practice interventions are being provided;
- Symptoms, diagnosis and/or functional impairment matches services requested and/or CA/LOCUS score;
- Medication(s) prescribed are pursuant to best practices;
- The information on the assessment correlates to the diagnosis listed
- The services requested are based on the prioritized list of needs, the LOCUS or CALOCUS level and the recipient's resources, abilities and recovery goals;
- The objectives are written in SMART (Specific, Measurable, Action-Oriented, Realistic and Time Limited) format;
- Interventions must be specific and include the intervention method and frequency of contact;
- Risk management issues have been identified and addressed;
- The ISRP includes an individualized, recovery focused crisis plan and the initial discharge plan;

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- The request packet includes all of the required documentation and signatures;
- All identifying information such as Social Security number, address, Medicaid number, is present; and
- A data file is submitted.

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

**Approval for Initial Services**

If the SAA unit approves the initial ISRP, the following authorization steps will be taken:

- SAA staff will input an end date for the interim authorization unless it has expired.
- SAA staff will input the initial authorization, which begins on the day after the review date and extends for up to ninety (90) days.

Approval letters are mailed to recipients. The approval notice is sent electronically through MHRIS to the provider.

**Denial for Initial Services**

If the services differ from those requested, the provider and the recipient will be notified regarding the denied services. The authorization request may be denied for any of the reasons identified in the MHR denial codes. The medical review psychiatrist may evaluate denied requests. The denial notice will include the recipient's appeal rights. The denial letter is mailed to the recipient and faxed to the provider.

**Phase Four (4): Conducting a Reassessment and Updating the ISRP**

To request additional services, the provider must conduct a reassessment to determine if the recipient continues to meet the medical necessity criteria for services and to determine his/her level of care. The provider may be required to:

- Conduct a reassessment, including rating the LOCUS or CALOCUS
- Enter the LOCUS or CALOCUS rating into MHRIS before submitting the authorization request.
- Update the ISRP. For a readmission or transfer, the provider will develop a new ISRP.

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- Review, sign, and date the e-CDI printout (LMHP and psychiatrist).
- Ensure the request packet includes all of the required documentation and signatures.
- Submit a data file.

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

The reauthorization request is submitted to the SAA unit. SAA staff reviews reassessment data and the ISRP to ensure services are delivered and that anticipated progress is made toward the established goals or the ISRP has been adjusted. This step allows the authorization staff to verify the medical necessity of ongoing care. The submitted information is reviewed according to authorization criteria that may include, but is not limited to, the following:

- The current requested services, the previous authorization request, and the amount of services delivered in the previous authorization period reflect the ongoing need for the types and level of services;
- The total length of stay in the program;
- The number of crises or hospitalizations. A high number of crises may provide justification for a higher number of services and fewer crises may result in justification of a lower number of services;
- Symptoms and medication in comparison to the previous quarter;
- The LOCUS or CALOCUS level decreasing or there is an explanation as to why the level has not decreased;
- The current and previous ISRP goals, objectives, and interventions address the needs identified in the reassessment
- The provider has clearly documented changes in the recipient's status.
- The recipient/family participated in defining recovery goals and objectives which are documented in the plan as indicated by recipient/family signature (all children six (6) and older must sign plan);
- Requested services are age, cognitively, culturally or developmentally appropriate
- Evidence based – best practice interventions are being provided
- Symptoms, diagnosis and/or functional impairment matches services requested and/or CA/LOCUS score
- Medication(s) prescribed are pursuant to best practice
- The information on the reassessment correlates to the diagnosis listed
- The services requested are based on the prioritized list of needs, the LOCUS or CALOCUS level and the recipient's resources, abilities and recovery goals;
- The objectives are written in SMART (Specific, Measurable, Action-Oriented, Realistic and Time Limited) format;

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- Interventions must be specific and include the intervention method and frequency of contact;
- Risk management issues have been identified and addressed;
- The ISRP includes an individualized, recovery focused crisis plan and the initial discharge plan;
- The request packet includes all of the required documentation and signatures;
- All identifying information such as Social Security number, address, Medicaid number is present; and
- A data file is submitted

**Approval for Continued Services**

If the request for authorization meets the requirements stated above, the request for services may be approved. Approval letters are mailed to recipients. The provider is sent the approval notice electronically through MHRIS.

**Denial for Continued Services**

If the services approved, differ from those requested, the provider and the recipient will be notified regarding the denied services. The authorization request may be denied for any of the reasons identified in the MHR denial codes. The medical review psychiatrist may evaluate denied requests. The denial notice will include the recipient's appeal rights. The denial letter is mailed to the recipient and faxed to the provider.

**Other Service Access and Authorization Activities****Request for Revision**

If a recipient needs additional services prior to the end of the authorization period, a request to revise the authorization must be submitted to the SAA unit. The provider must:

- Complete a Request for Revision Form
- Update the ISRP
- Update the crisis plan
- Rate the LOCUS or CALOCUS
- Enter the rating into MHRIS
- Ensure the request packet includes all of the required documentation and signatures
- Submit a data file

**NOTE:** A request for revision may not be submitted during the interim authorization period.

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The revision request is submitted to the SAA unit and is reviewed according to authorization criteria that may include, but is not limited to, the following:

- The recipient is a danger to self or others, and is at risk for displacement (i.e. psychiatric hospitalization, therapeutic out of home placement, or incarceration);
- Two-thirds of the current/active units approved by SAA have been utilized;
- Referrals for the appropriate and medically necessary specialty services have been made but the service(s) are not available;
- The request packet includes all of the required documentation and signatures;
- The provider has clearly documented changes in the recipient's status;
- The recipient/family is actively participating in the treatment as indicated by signatures on the ISRP; The recipient is making progress towards meeting recovery goals; or the goals, objectives or intervention methods have been revised on the ISRP;
- The goals and objectives reflect the strengths, priorities and identified needs of the recipient and reflect a recovery/resiliency philosophy; and
- Risk management issues have been identified and addressed.

**Approval for Revision**

If the request for authorization meets the requirements stated above, the request for services may be approved. Approval letters are mailed to recipients. The provider is sent the approval notice electronically in MHRISIS.

**NOTE:** If the request for revision of PFII services is approved, the current authorization will be canceled. A new authorization for PFII services will be issued.

**Denial for Revision**

If the services approved, differ from those requested, the provider and the recipient will be notified regarding the denied services. The authorization request may be denied for any of the reasons identified in the MHR denial codes. The medical review psychiatrist may evaluate denied requests. The denial notice will include the recipient's appeal rights. The denial letter is mailed to the recipient and faxed to the provider

**CHAPTER 31: MENTAL HEALTH REHABILITATION****SECTION 31.2: SERVICE ACCESS/AUTHORIZATION PAGE(S) 11****Access to Emergency Services**

To assure the quality and accessibility of services, a continuity of care procedure will be followed for recipients being discharged from any twenty four (24)-hour care facility when discharge is dependent upon the availability of follow-up mental health services.

This may include, but is not limited to, discharges from juvenile detention facilities, psychiatric hospitals or distinct part psychiatric units.

**NOTE:** No services may be billed while the recipient is a patient in a twenty four (24)-hour care facility except on the date of discharge. On the day of admission to a health care facility, providers may not bill for services.

**New Recipients**

The provider selected by the recipient must participate in discharge planning with the facility. The provider must complete phase one and phase two of the Service Access and Authorization Process. On the date of discharge from the twenty-four (24) hour care facility, the assessment packet, if completed, must be signed and dated by the LMHP and faxed to the SAA unit. The cover page must be marked, "Emergency PA" in black marker. The discharge instruction form from the twenty-four (24) hour care facility must be submitted to verify the date of discharge. The SAA unit will render a decision within one (1) working day.

**Active Recipients**

The provider must participate in discharge planning with the facility, taking care to note the expiration date of the existing authorization. The provider shall submit a new authorization request as outlined in phase four of the Service Access and Authorization Process or submit a request for revision on the date of discharge as appropriate. The cover page must be marked, "Emergency Authorization" in black marker. The discharge instruction form from the twenty-four (24) hour care facility must be submitted to verify the date of discharge. The SAA unit will render a decision within one (1) working day.

**Recipient Transfer**

When an active recipient selects a new provider during an authorization period, the current provider must send all requested documentation to the new provider upon receipt of the consent to release information form signed by the recipient within two (2) working days following the request. The provider may charge a reasonable fee to make copies. The recipient must be closed in MHRSIS and the closure form must be sent to the SAA unit.

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The authorization for the current provider will be cancelled on the date the recipient notifies the SAA unit they wish to change providers. This confirmation may be provided to the SAA unit by the recipient in writing or by telephone.

For the new provider, if the last date of service with the previous provider was within the past twelve (12) months, the new provider must:

- Obtain a Freedom of Choice signed by the recipient
- Open the recipient in MHRISIS
- Send a data file before submitting the authorization request.

The new provider will be issued a thirty (30) day interim authorization. A sixty (60) day authorization will be issued if the provider receives five (5) or more requests for transfer at one time, such as when a neighboring provider closes.

During the interim authorization period, the new provider must complete phase four (4) of the Service Access and Authorization Process.

If the last date of service has been more than twelve (12) months, the recipient must be readmitted to the program. The provider must complete phase one (1) and phase two (2) of the Services Access and Authorization Process before requesting an authorization for services.

**Recipient Readmission**

If a recipient requests to re-enter the program and selects a provider who had previously provided services within the past twelve (12) months, the provider must complete phase four of the SAA process before requesting an authorization for services.

If the last date of service has been more than twelve (12) months, the recipient must be readmitted to the program. The provider must complete the phase one (1) and phase two (2) of the Services Access and Authorization Process before requesting an authorization for services.

**NOTE: An Initial Assessment will only be issued if a recipient has not received MHR services within the past twelve (12) months.**



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**CHAPTER 31: MENTAL HEALTH REHABILITATION**

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**SECTION 31.2: SERVICE ACCESS/AUTHORIZATION PAGE(S) 11**

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**Reconsideration**

If the provider does not agree with the decision of the SAA unit, reconsideration may be requested. The provider must FAX the original denial letter with **RECON** written across the front, including additional information, to the SAA unit. The SAA Unit will render a decision on the reconsideration request. If the request is approved, it will not be backdated. The provider and recipient will be notified of the decision within fourteen (14) calendar days of the receipt of the request for reconsideration. If the request is denied, the denial notice will include the recipient's appeal rights.

**Appeal Process**

If the recipient continues to be dissatisfied with the decision, he/she may file an appeal through the Department of Health and Hospitals (DHH) appeals process. The recipient must send the request for a fair hearing to the DHH Bureau of Appeals within thirty (30) days of receipt of the denial notice.

**Provider Closure**

Prior to the voluntary closure, the provider will notify all recipients of the pending closure, provide a Freedom of Choice form to assist them in choosing another provider or other treatment resources. The provider should coordinate with the new treatment resource to ensure the recipient has sufficient medication. Upon the recipient's written consent, the provider must make copies of the recipient's record available. The provider must complete the MHRIS Closure Form and submit it to the SAA unit. The SAA unit will monitor this procedure.

If the closure is involuntary, the provider shall assist recipients with transitioning to other mental health services. This shall include the development of a transition plan for each recipient.

**NOTE:** For more information regarding a provider closure, refer to Section 31.3 - Changes or Events That Must Be Reported.

**Re-establishing Services to Displaced Recipients Due to Disaster**

When a situation is deemed a disaster by DHH, procedures may be established in response to the disaster to ensure recipients have access to services which are medically necessary to maintain continuity of care. Any procedures established by DHH shall be consistent with program rules

## **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

OMH and the fiscal intermediary conduct the initial provider certification and enrollment reviews. OMH reviews the MHR certification application to ensure the applicant meets MHR certification criteria. The OMH 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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**CHAPTER 31: MENTAL HEALTH REHABILITATION**

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**SECTION 31.3: PROVIDER CERTIFICATION AND  
RECERTIFICATION****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) 922-0006 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 unqualified 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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**CHAPTER 31: MENTAL HEALTH REHABILITATION**

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**SECTION 31.3: PROVIDER CERTIFICATION AND****RECERTIFICATION****PAGE(S) 11**

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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:

The Office of Mental Health  
1885 Wooddale Blvd., 9<sup>th</sup> Floor  
Baton Rouge, LA 70806

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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**CHAPTER 31: MENTAL HEALTH REHABILITATION**

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**SECTION 31.3: PROVIDER CERTIFICATION AND  
RECERTIFICATION****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 OMH to ensure the applicant meets standard criteria for providing the services. The OMH 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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**CHAPTER 31: MENTAL HEALTH REHABILITATION**

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**SECTION 31.3: PROVIDER CERTIFICATION AND  
RECERTIFICATION****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:

The Office of Mental Health  
Attn: Network Services  
1885 Wooddale Blvd., 9<sup>th</sup> Floor  
Baton Rouge, LA 70806

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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- If the applicant requests a site visit within thirty (30) days, a site review may be scheduled.
- If the site meets all operational requirements, the certification request may be approved and forwarded to Provider Enrollment for further processing.
- If at the site review all operational requirements are not met, the provider will be notified of the deficiencies.
  - The applicant will have thirty (30) days from the date of receipt of the notice to correct any deficiencies and request a second site review.
  - A second site review may be conducted if deemed necessary by the bureau.
  - If the applicant fails to correct all deficiencies or to schedule a second site review, certification may be denied.

**Initial Certification Approval and Enrollment**

The fiscal intermediary may enroll the prospective provider requesting initial certification once the Bureau certifies compliance with all policy and operational requirements. All provider enrollment requirements must be met before a Medicaid number is issued. If the prospective provider fails to meet any certification requirements, they may not be enrolled as an MHR provider. The applicant shall undergo the entire review process detailed above, if and when it reapplies for certification.

**Loss of Certification**

There may be an immediate loss of certification if at any time the enrolled MHR provider fails to maintain program requirements or accreditation status. The provider may not reapply for certification for one year following the effective date of termination.

**Discontinuation of Adult PSR and PFII Services**

The provider must notify the Bureau of the intent to discontinue adult PSR or PFII services thirty (30) days in advance, stating the reason for discontinuing the service. Prior to discontinuance, each recipient must be offered a Freedom of Choice form from which to choose a new provider.

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**CHAPTER 31: MENTAL HEALTH REHABILITATION**

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**SECTION 31.3: PROVIDER CERTIFICATION AND  
RECERTIFICATION****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:

The Office of Mental Health  
Attn: Network Services  
1885 Wooddale Blvd., 9<sup>th</sup> Floor  
Baton Rouge, LA 70806  
Fax: 225-925-4789 or 225-922-2165

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.



**CHAPTER 31: MENTAL HEALTH REHABILITATION****SECTION 31.3: PROVIDER CERTIFICATION AND  
RECERTIFICATION****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:

The Office of Mental Health  
Attn: Network Services  
1885 Wooddale Blvd., 9<sup>th</sup> Floor  
Baton Rouge, LA 70806  
Fax: 225-925-4789 or 225-925-4789

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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**CHAPTER 31: MENTAL HEALTH REHABILITATION**

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**SECTION 31.3: PROVIDER CERTIFICATION AND  
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**Changes or Events That Must Be Reported**

Certain changes or events must be reported in writing to OMH 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 OMH**

All changes reported to OMH must be faxed to Network Services at 225-925-4789 or 225-922-2165 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 225-922-0006.

**Change of Address**

A Change Report Form with the following attachments must be submitted to OMH 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 OMH sixty (60) days prior to the first day of operation in the new location. OMH 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 OMH 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 OMH 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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**CHAPTER 31: MENTAL HEALTH REHABILITATION**

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**SECTION 31.3: PROVIDER CERTIFICATION AND  
RECERTIFICATION****PAGE(S) 11****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 OMH 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 OMH 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 OMH.
- Any other occurrence, which affects compliance with certification requirements.

## **PROGRAM OPERATIONS**

### **General Provisions**

The policies and procedures in this section specify requirements necessary to provide effective services. The provider shall:

- Assume full responsibility for the delivery of all services, including those delivered through contracts, subcontracts, or consultant agreements.
- Ensure that services provided by contractors, subcontractors and consultants conform to all federal and state regulations regarding delivery and documentation of services and staff qualifications.
- Immediately report any suspected or known violations of any civil or criminal law to the appropriate authority and to the Bureau.
- Maintain written procedures and implement all required policies and procedures immediately upon acceptance of recipients for services.
- Request an expedited prior authorization review for any recipient whose discharge from a twenty-four (24) hour care facility is dependent on follow-up mental health services.
- Accept full responsibility to ensure that the office locations meet all applicable federal, state, and local requirements. The transferring of certifications to a new location is strictly prohibited.

### **Organizational Structure**

The provider must maintain a current, functional organizational chart that defines the lines of authority. The owner must designate an administrator who will have overall responsibility for management of daily operations. The administrator or designee shall be accessible to the Bureau's staff during all normal business hours.

**Cooperative Agreement**

The provider agrees to cooperate with the Bureau with regard to recertification, monitoring of all service related activities, and any function that may affect recipients. The provider also agrees to require each contracted person or entity to sign an agreement to comply with the requirements stated above. This may include interviewing the staff, recipients, family or other stakeholders and observation of services.

The provider must have an identifiable governing body. The names and addresses of all members of the governing body, their terms of membership, officers and their terms of office must be documented. The governing body must:

- Include recipient and family representation.
- Hold formal meetings at least semi-annually to discuss programmatic and administrative operations, have written minutes of all formal meetings, and by-laws specifying frequency of meetings and quorum requirements.
- Have specific responsibility and authority over the policies and activities of the provider and:
  - Ensure the provider's compliance with its articles of incorporation and/or its charter;
  - Ensure the provider's continual compliance with all relevant federal, state, local, and municipal laws and regulations;
  - Ensure that the provider is adequately funded and fiscally sound;
  - Review and approve the provider's annual budget;
  - Review and approve the annual external fiscal audit or audit review by a certified public accountant;
  - Designate a qualified individual, based on the owner's recommendation, to act as administrator, delegate sufficient authority to this person to manage the agency, and annually evaluate the administrator's performance; and
  - Formulate and annually review, in consultation with the administrator, written policies concerning the provider's philosophy, goals, current services, personnel practices, job descriptions and fiscal management.

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

The provider shall develop, maintain, and implement a written internal policy manual. The provider must document that staff has been trained on the policy manual and make it available to all staff. The manual must be made available to the Bureau and recipients upon request. The manual must include the following:

- A policy governing creation and retention of administrative and personnel records;
- A policy to utilize the current MHRIS (or its successor) system to include accurate, current provider staff and recipient information;
- Written procedures for maintaining the security and the confidentiality of recipient records;
- A comprehensive training policy for all employees, volunteers and students which meets specified requirements;
- A brief description of services provided;
- A policy and procedure for hospitalization that conforms with the Single Point of Entry (SPOE) policy and procedure;
- A procedure for referrals to services not offered by the provider, including PFII and PSR;
- A procedure for subcontracting optional services;
- A policy for adhering to Americans with Disabilities Act (ADA) guidelines;
- An operations policy that includes a mission statement, program philosophy, and goals of the provider;
- A complaint resolution procedures, including DHH as the final point of resolution;
- A policy and procedure regarding abuse, neglect, extortion or exploitation;

Providers must have a policy that clearly defines abuse, neglect, extortion and exploitation of children and adults. All such policies and definitions must be in accordance with applicable state and federal laws, including, but not limited to the following:

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- LSA-R.S. 14:403.2 et seq. (or subsequent updates);
- LSA-Ch.C Art. 601 et seq. (or subsequent updates).
- LSA-R.S. 40:2009.13 et seq. (or subsequent updates);

Providers must have a procedure for reporting suspected cases of abuse, neglect, extortion or exploitation as required by law. The procedure must include the mandatory reporting by staff of any suspected cases of abuse, neglect, extortion or exploitation. A staff member, subcontractor, volunteer or intern who witnesses, has knowledge of, or otherwise has reason to suspect that such an incident may have occurred must report the incident to the appropriate law enforcement and state agencies such as Office of Community Services (OCS), Child Protection, Adult Protective Services, and the Bureau. This includes incidents that occur in the provider offices as well as situations that may arise outside the office.

Providers must also have an internal procedure to investigate and report such incidents allegedly committed by an employee. The procedure shall include, at a minimum, the following:

- Steps to take to report the incident to the appropriate law enforcement and state agencies such as the OCS, Adult Protective Services, and the Bureau.
  - Any allegation of abuse, neglect, extortion or exploitation lodged against an employee must be reported to the administrator, and the administrator must cooperate in any investigation of the incident.
  - Individuals under investigation are not to be part of the investigation team.
  - Individuals under investigation are prohibited from working or having any contact with the recipient who made the allegation.
  - The findings of the investigating team are to be reviewed by the appropriate administrative level and forwarded to the governing body.
  - In substantiated cases of neglect, appropriate action must be taken to prevent a reoccurrence.
  - In substantiated cases of abuse, extortion or exploitation, the employee must be terminated.
  - Steps to be taken for referral and reporting to appropriate licensing board.
- Employment and personnel policies;  
Each provider must have written employment and personnel policies, which includes job descriptions for all positions that specify duties, qualifications, and competencies. It must also describe the hiring policies and practices including the following:



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- Prevention of discrimination based on race, color, religion, sex, age, national origin, disability, disabled veteran, or any other non merit factor.
- Provision for recruitment and employment of recipients of mental health services and family members of children with emotional/behavioral disorder.
- A description of the procedure for employee evaluation and promotion.
- A procedure for disciplinary action, termination, and hearing of employee grievances.
- A procedure for maintenance of time and attendance logs for all employees and contractual staff.
- A procedure for the creation and retention of personnel records.
- A procedure for conducting Tuberculosis (TB) Tests. Each provider must coordinate processes to reduce the risk of such infections in recipients and staff. Skin testing procedures should be made part of the provider's infection control program. All persons, prior to or at the time of employment shall be free of TB in a communicable state.

Any employee who has a negative Mantoux skin test for TB shall be retested annually in order to remain employed. Any employee who has a positive Mantoux skin test must provide evidence of a normal chest X-ray, a statement from a physician certifying that the individual is non-infectious if the chest X-ray is other than normal or completion of an adequate course of therapy as prescribed by a licensed physician, if active TB is diagnosed. Any employee who has a positive Mantoux skin test must provide an annual physician's statement as evidence that they are free of TB in a communicable state.

- Policies and procedures regarding personal safety of staff while providing services;
- A policy on criminal background checks;

Providers must conduct criminal background checks through the Louisiana Department of Public Safety, State Police on all employees prior to employment. If the results of any criminal background check reveal that the employee was convicted of any offenses against a child/youth or an elderly or disabled person, the employer shall not hire and/or shall terminate the employment of such person. In the case of an individual with a criminal background record involving other offenses, the provider should exercise caution and good judgment in conjunction with their liability insurance carrier regarding hiring that individual. The provider shall not hire an individual with a record as a sex offender nor permit these individuals to work for the provider as a subcontractor.

If the provider offers services to children/youth, the background checks must be performed as required by R.S. 15:587.1 and R.S. 15:587.3 et seq.

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To avoid delays in processing the background check, the form must be completed by the MHR provider with "employer" selected. This will produce a statewide check. If the individual resided or was employed in another state, that state needs to be checked as well. If the healthcare provider works with children, then instead of selecting "employer" on the form, "working with children" should be selected in order to comply with Louisiana statute, LSA RS 15.587.3.

- A policy on drug testing;

The provider shall have a policy to ensure an alcohol and drug-free workplace and a workforce free of substance abuse. The policy must include:

- A pre-employment drug screen before an offer of employment is made. A prospective employee who tests positive for the presence of illegal drugs in the initial screening shall be eliminated from consideration for current employment.
  - A provision prohibiting employees from reporting for work or performing work with alcohol, illegal drugs, controlled substances, or designer (synthetic) drugs present in their bodies.
  - A prohibition from illegal use, possession, dispensation, distribution, manufacture, or sale of controlled substances, designer (synthetic) drugs, and illegal drugs at the work site and while on official business, on duty or on call for duty.
  - A provision for random drug testing of employees and a written plan to handle employees who test positive for illegal drug use whether the usage occurs at work or during off duty hours.
  - Documentation shall be readily retrievable upon request by the Bureau.
- A financial management policy;

The provider shall establish a system of business management and staffing to assure maintenance of complete and accurate accounts, books and records in keeping with generally accepted accounting principles. The provider:

- Must demonstrate fiscal accountability through regular recording of its finances and an annual external audit or audit review conducted by a certified public accountant in accordance with government auditing principles.
- Must be capable of reporting fiscal data from July 1 through June 30.
- Must maintain adequate funding for required staff and services.
- Must maintain a separate business bank account.

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- A recipient orientation policy;

Orientation must be conducted for all new recipients and annually thereafter. Information must be provided to the recipient verbally and in writing. The recipient must sign an acknowledgement form that he/she received the information. A copy of the signed acknowledgement form must be given to the recipient. The orientation information must include the following:

- A mission statement;
- Array and type of intervention services offered;
- Staff qualifications;
- A statement of afterhours access to services;
- Recipients crisis management procedures, including de-escalation;
- Complaint resolution procedures, including DHH as the final point of resolution;
- Discharge planning procedure;
- Information as required by the Bureau including but not limited to a consumer handbook;
- Emergency preparedness plan;
- Seclusion and restraint policy; and
- Recipient's rights including but not limited to:
  - Freedom to choose his/her provider,
  - The right to ask for a different provider,
  - The right to request changes to their ISRP, crisis plan, and discharge plan,
  - The right to confidentiality,
  - The right to review their record,
  - The right to complain about their services without fear of reprisal, such as discontinuance of services, and
  - The right to be free from being restrained or secluded, unless necessary to protect him/herself or others from harm.

**NOTE:** Recipients have these rights regardless of their age, race, sex, religion, culture, lifestyle, ability to communicate, and disability.

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

The provider shall have systems and procedures for the ongoing monitoring of the quality, appropriateness and utilization of services delivered. Data collected must be reliable, valid, complete and accurate. Provider staff performing the quality management (QM) function should be knowledgeable regarding QM procedures.

Findings should be used to make programmatic changes, to identify training needs, to improve the quality of services and in financial and resource planning. Input from recipients and other stakeholders, obtained through public hearings, representation on advisory committees, or small focus groups, must be an integral part of the process. Documentation must include:

- Staff member who performed the QM function,
- Written statement noting all deficiencies found,
- Evidence that action was taken as a result of the findings to prevent reoccurrence of the deficiency,
- Documentation of who performed the follow up action,
- A review of a representative sample of recipient records that include MHRIS reports and service logs to assure compliance with the ISRP,
- A comprehensive recipient satisfaction survey conducted annually, and
- Outcome data regarding the effectiveness of the program.

**Program Philosophy**

The provider must describe the program philosophy and all relevant program standards that include the following:

- Using input from the recipient and from others such as family members, caregivers and advocates.
- Sharing information with the recipient and with parents/guardians in the case of children and youth.
- Supporting recovery of the recipient.
- Enhancing the quality of life for the recipient.
- Reducing symptoms.
- Supporting the integration of the recipient into the community.
- Developing an ISRP for each recipient with goals based on an assessment.

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

The provider must establish regular business office hours for all certified and enrolled office locations. These locations must be fully operational at least eight (8) hours a day, five (5) days a week between 7 a.m. and 7 p.m.

**NOTE:** This requirement does not apply to off-site service delivery locations.

Each office shall contain office equipment and technology that meets requirements established by the Bureau (Appendix A) and furnishing requisite to providing services including but not limited to:

- Computers
- Facsimile machines
- Telephones
- Lockable file cabinets

Offices shall be located in areas separate and apart from areas of residential occupancy and be clearly identifiable as a separate office. The environment must be appropriate to the care and treatment of the recipients and ensure confidentiality and personal safety.

An office location is fully operational when the provider:

- Is certified to offer Mental Health Rehabilitation services and is enrolled in Medicaid.
- Has at least five active recipients at the time of any recertification or monitoring review, other than the initial application review. To be considered active, a recipient must be authorized for services.
- Is capable of accepting referrals at any time during regular business hours.
- Retains adequate staff to assess process and manage the needs of current recipients.
- Has the required designated staff on-site (at each location) during business hours.
- Is immediately available to its recipients and the Bureau by telecommunications twenty-four (24) hours per day. **Note:** Recipients should have an agency contact number for use in emergencies and should not automatically be directed by voice mail or staff to call 911 or go to an emergency room.
- Maintains insurance coverage.

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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 OMH regarding this reportable change as outlined in the Provider Certification and Recertification section of this manual (section 31.3). OMH 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.

## **STAFFING AND TRAINING**

The Bureau has established staffing requirements to maintain an adequate level of effective, efficient, and professional services. The provider must ensure that the staff members possess the minimum requisite skills, qualifications, training, supervision, and coverage in accordance with the requirements described in this section.

### **Staffing Requirement**

Appropriate staffing must be available to adequately implement the ISRP for each recipient. Loss of required staff is a reportable change to the Bureau. In the event a required staff member, such as a psychiatrist, leaves employment, the provider has up to thirty (30) days to hire a replacement. All staff lists must be maintained and up to date in MHR SIS.

### **Personnel Records**

A personnel records creation and retention policy shall be developed, implemented and maintained by the provider. The provider shall maintain documentation and verification of all relevant information necessary to assess qualifications for all staff, volunteers and consultants. All required licenses as well as professional, educational, work experience and dates of employment must be verified. All verifications must be documented in the employee's or agent's personnel record prior to the individual providing billable Medicaid services.

The personnel records shall include the following documentation:

- Current resume or employment application, which must include documentation of previous employment,
- Employee credentials including current professional license, diploma and official transcripts,
- Valid Louisiana (LA) driver's license and current automobile insurance;
- Employee training and orientation documentation as required by the Bureau,
- Completed ACE application and approval by the Bureau,
- CPRP application, approval letter from USPRA and all other related documents, as applicable,
- Three (3) references,

References must be obtained prior to employment, for any employee who will be directly providing services. At least two (2) of the references must be professional and/or work related. Professional/work related references must be explicit with regard to previous work experience and performance. The reference documentation must include the date, address and telephone number of the individual who is providing the reference.

**CHAPTER 31: MENTAL HEALTH REHABILITATION****SECTION 31.5: STAFFING AND TRAINING****PAGE(S) 14**

- Annual performance evaluations,
- Employment experience and dates of employment  
Employment verification shall include written documentation from a previous employer or a signed statement verifying that they spoke with the previous employer through verbal contact. The statement should assure and document, the applicant's experience, and include the name, address and current telephone numbers of the former employer or supervisor. If the past employer is no longer in business, and employment cannot be verified by personnel, that job experience may not be included toward required experience. The month and year of past employment must be documented.

Experience must be in a paid, forty (40) hours per week position. Experience obtained while working in a position for which the individual is not qualified may not be counted as experience. If experience is in a part-time position, the staff person must be able to verify the amount of time worked equals the required time period for full time employment. College work/study or internship related to completion of a degree cannot be counted as work experience.

- Education Verification  
Educational documents, including diplomas, degrees and certified transcripts shall be maintained in the records. All college degrees must be from a nationally accredited institution of higher education as defined in Section 102(b) of the Higher Education Act of 1965, as amended.

**Confidential Information**

The following shall be maintained in a separate confidential file available for review when requested by the Bureau or other legitimate governmental entities:

- Drug testing results,
- Criminal background check, and
- TB test results.

**Staff Qualifications**

Services shall be provided by individuals who meet the following education and experience requirements:

**NOTE: All documents must be maintained and readily retrieved for review by the Bureau.**



**CHAPTER 31: MENTAL HEALTH REHABILITATION****SECTION 31.5: STAFFING AND TRAINING****PAGE(S) 14****Licensed Mental Health Professional (LMHP)**

An LMHP must be a graduate of an accredited institution with a degree in a mental health-related field and is licensed to practice in the state of Louisiana by the applicable professional board of examiners. An LMHP provides professional mental health services within the scope and ethical boundaries allowed by the professional license.

The following professionals are considered LMHPs:

- Psychiatrist
- Psychologist
- An advanced practice registered nurse (APRN), who is a clinical nurse specialist in psychiatry or a Nurse Practitioner (NP) certified in psychiatry or mental health nursing
- Licensed Clinical Social Worker
- Licensed Professional Counselor

**Psychiatrist**

Providers shall have a contract with a psychiatrist(s) to provide consultation and/or services at the MHR office, an off-site service delivery location, or in a recipient's natural environment (home or school) as medically necessary. The psychiatrist must be a licensed medical doctor (M.D. or D.O.) who is board-certified or board-eligible, authorized to practice psychiatry in Louisiana, and enrolled to participate in the Louisiana Medicaid Program.

A board eligible psychiatrist may provide psychiatric services to MHR recipients if he/she:

- Holds an unrestricted license to practice medicine in Louisiana and unrestricted Drug Enforcement Administration (DEA) and state and federal controlled substance licenses. If licenses are held in more than one state or jurisdiction, all licenses held by the physician must be documented in the employment record and be unrestricted.
- Has satisfactorily completed a specialized psychiatric residency training program accredited by the Accreditation Council for Graduate Medical Education (ACGME), as evidenced by a copy of the certificate of training or a letter of verification of training from the training director which includes the exact dates of training and verification that all ACGME requirements have been satisfactorily met. If training was completed in child/youth psychiatry, the training director of the child/youth psychiatry program must document such training.

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- If training was completed in a psychiatric residency program not accredited by the ACGME, the physician must demonstrate that he/she meets the most current requirements as set forth in the American Board of Psychiatry and Neurology's Board Policies, Rules and Regulations regarding information for Applicants for Initial Certification in Psychiatry.

**Psychologist**

An individual licensed as a practicing psychologist under the provisions of R.S. 37:2351– 2367.

**Advanced Practice Registered Nurse (as LMHP)****A nurse as an LMHP must:**

Be an Advanced Practice Registered Nurse (APRN)/Clinical Nurse Specialist (CNS) or Nurse Practitioner (NP), certified by a nationally recognized certifying body such as the American Nurses Credentialing Center in psychiatry and licensed by the Louisiana State Board of Nursing.

An APRN must be enrolled to participate in the Louisiana Medicaid Program and must operate under an approved collaborative practice agreement with a board-certified or board eligible psychiatrist. The Louisiana Board of Nursing must approve the practice agreement prior to delivering services.

For information regarding an APRN Collaborative Practice Agreement, see “Forms” at the website [www.lsbn.state.la.us](http://www.lsbn.state.la.us).

**Licensed Clinical Social Worker**

An individual who has a master's degree in social work from an accredited school of social work and is a licensed clinical social worker under the provisions of R.S. 37:2701 – 2723.

**Licensed Professional Counselor**

An individual, who has a master's degree in a mental health-related field, Licensed under the provisions of R.S. 37:1101 – 1115 and has two (2) years post-masters experience in mental health.

**CHAPTER 31: MENTAL HEALTH REHABILITATION****SECTION 31.5: STAFFING AND TRAINING****PAGE(S) 14****Approved Clinical Evaluator (ACE)**

An LMHP who conducts an initial assessment or reassessment must meet all Approved Clinical Evaluator (ACE) standards including attending training conducted by the Bureau. Initial ACE approval may be denied if the LMHP does not demonstrate competency in completing assessments based on factors including, but not limited to, participation in training activities and rating sample cases. ACE approval may be suspended or revoked if assessments do not accurately reflect the needs of recipients, or if an ACE does not attend additional training as requested by the Bureau.

ACE staff must complete and return all required documentation including a current ACE application to ensure that the Bureau has current information regarding his/her employment.

**Mental Health Professional (MHP)**

A Mental Health Professional (MHP) must meet the following educational criteria.

- A Master of Social Work degree;
- or**
- A Master of Arts, Science or Education degree in a mental health related field (refer to the Glossary for a definition of a mental health related field);
- and**
- A minimum of fifteen (15) hours of graduate level course work and/or practicum experience in applied intervention strategies/methods designed to address behavioral, emotional and mental disorders as a part of, or in addition to the master's degree.

**NOTE:** The MHP must work under the supervision of an LMHP.

**Mental Health Specialist (MHS)**

A Mental Health Specialist must meet the following educational criteria.

- A Bachelor's degree in a mental health related field;
- or**
- A Bachelor's degree, enrolled in college and pursuing a graduate degree in a mental health related field and has completed at least two (2) courses identified in a mental health related field;
- or**
- A high school diploma or a GED, and at least four (4) years experience providing direct services in a mental health, physical health, social services, education or correctional setting.

**NOTE:** The MHS must work under the supervision of an LMHP.

**CHAPTER 31: MENTAL HEALTH REHABILITATION****SECTION 31.5: STAFFING AND TRAINING****PAGE(S) 14****Registered Nurse (RN)**

A registered nurse (RN) licensed by the Louisiana State Board of Nursing or a licensed practical nurse licensed by the Louisiana Board of Practical Nurse Examiners may provide designated components of medication management services if he/she meets the following requirements:

A registered nurse must have:

- A Bachelor's degree in nursing and one (1) year of supervised experience as a psychiatric nurse which must have occurred no more than five (5) years from the date of employment with the provider;
- or**
- An Associate degree or diploma in nursing and two (2) years of supervised experience as a psychiatric nurse which must have occurred no more than five (5) years from the date of employment with the provider;
- and**
- Six (6) Continued Education Unit (CEUs) regarding the use of psychotropic medications, including atypicals, prior to providing direct services to recipients.

**NOTE:** Supervised experience is experience in mental health services delivery acquired while working under the formal supervision of an LMHP.

**Licensed Practical Nurse (LPN)**

A licensed practical nurse licensed by the Louisiana Board of Practical Nurse Examiners may perform medication administration if he/she has:

- One year of experience as a psychiatric nurse which must have occurred no more than five (5) years from the date of employment with the MHR provider;
- and**
- Six (6) CEUs regarding the use of psychotropic medications, including atypicals, prior to providing direct services to recipients.

**NOTE:** Registered nurses and licensed practical nurses providing services shall have documented evidence of five (5) CEUs annually which are specifically related to behavioral health and medication management issues.

**CHAPTER 31: MENTAL HEALTH REHABILITATION****SECTION 31.5: STAFFING AND TRAINING****PAGE(S) 14****Staff Responsibilities**

The LMHP is responsible for all clinical services and supervision of all non-licensed staff. The LMHP must:

- Direct the collection of data for the initial assessment and reassessments.
- Conduct, at a minimum, one face-to-face interview with the recipient and their family/significant others during an initial assessment and reassessments.
- Provide DSM-IV (or its successor) diagnoses, Axes I-V if qualified to do so.
- Develop, sign and date the initial assessment and reassessment.
- Develop, sign and date the initial ISRP.
- Develop or review, sign and date ISRP updates.
- Develop, sign, and date Request for Revision form.
- Administer and score LOCUS/CALOCUS, if an ACE, as part of the initial assessment, reassessments, with each Request for Revisions, or as required by the Bureau.
- Act as team leader of the service planning team.
- Provide crisis intervention services as needed.
- Notify the provider's staff psychiatrist of any significant change in a recipient's physical or mental status.

The LMHP may:

- Provide all core services except medication management, unless qualified to do so.
- Act as team leader for a PFII team.
- Act as program director for a PSR program.
- Provide staff training as needed.
- Perform the quality management function as needed.
- Supervise non-LMHP staff.
- Review and sign the Electronic Case Data Inquiry (e-CDI) screen print. If no data is available, the screen print must also be signed.

A psychiatrist must:

- Have a face-to-face interview with the recipient at initial assessment.
- Review and sign the Medical History Questionnaire section of the initial assessment during a face-to-face contact.
- Review and sign the ISRP at initial assessment and reassessment.
- Review and sign the Electronic Case Data Inquiry (e-CDI) screen print. If no data is available, the screen print must also be signed.

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- Be available to participate in crisis intervention emergencies.
- Provide face-to-face, medically necessary, services on site for each recipient who has selected the provider's staff psychiatrist. If consultation or a service with a recipient is not required on a monthly basis, the psychiatrist must provide documentation of the rationale for a reduction in the frequency of services.

The psychiatrist may

- Provide DSM-IV (or its successor) diagnoses, Axes I-V.
- Provide medication management.
- Participate in team meetings.

An advanced practice registered nurse (APRN) or a nurse practitioner **may** provide DSM-IV (or its successor) diagnoses, Axes I-V and medication management.

**NOTE:** The requirements listed above must be provided by an MHR or non-MHR Psychiatrist. If a recipient chooses a non-MHR psychiatrist, the provider is required to ensure all requirements are met.

An MHP **may** provide the following services:

- Community support,
- Initial assessment and reassessments (billed by the LMHP only),
- Individual and/or group counseling,
- Group Psychosocial Skills Training (youth and adults),
- Parent Family Intervention (Counseling),
- Parent Family Intervention (Intensive), and/or
- Participate in quality management and staff training activities.

An MHS **may** provide the following services:

- Community support,
- Initial assessment and reassessments (billed by the LMHP only),
- Group psychosocial skills (youth and adults),
- Parent Family Intervention (Intensive), and/or
- Participate in quality management and staff training activities.

A registered nurse **may** provide aspects of Medication Management within the scope of his/her practice.

A licensed practical nurse **may** provide medication administration.

**CHAPTER 31: MENTAL HEALTH REHABILITATION****SECTION 31.5: STAFFING AND TRAINING****PAGE(S) 14****Backup Staff**

In the event a staff member is not available, back up staff must meet all staff qualifications, training, and supervision requirements outlined in the manual. Critical clinical information, including the comprehensive crisis plan, the current assessment, and the current ISRP, must be available to the back-up staff.

**Supervision**

Every unlicensed employee providing direct clinical services shall receive continuing direct and documented clinical supervision from a licensed mental health professional. Supervision shall be carried out by the LMHP who is directly responsible for the recipient. Peer supervision may not be used.

Employees must have an individualized supervisory plan completed within the first month of employment and updated annually thereafter. Supervisory sessions must include a record of the date, time, length of session, type of supervision and a summary of observation and recommendations concerning job performance.

Supervision of staff shall include direct clinical review, assessment and feedback regarding the delivery of services, and teaching and monitoring of the application of recovery/resiliency and Child and Adolescent Service System Program (CASSP) principles and practices. Supervision must be provided in a culturally sensitive manner that represents the cultural needs and characteristics of the staff and the service area. Supervision must be available by telephone whenever the employees are delivering services or are on call. A roster specifying the on-call supervision schedule must be provided to all employees.

The following supervisory methods may be used:

- A face-to-face session with individual employees to review cases, assess performance and provide feedback.
- A session in which the supervisor observes and assesses an employee during the delivery of services to recipient(s), followed by feedback regarding the employee's performance.
- Face-to-face sessions with a group of six (6) or fewer employees to problem-solve, provide feedback, and generate peer supervision and support.
- Supervisory reviews of recipient records for evaluation and feedback on employee job performance.
- Annual performance evaluations.
- Review of recipient reports and staff meetings that assess the recipient's performance and provide the staff direction regarding individual cases.

**CHAPTER 31: MENTAL HEALTH REHABILITATION****SECTION 31.5: STAFFING AND TRAINING****PAGE(S) 14****Initial Supervision**

Non-LMHP staff shall receive face-to-face supervision and observation for a minimum of two (2) hours each week for the first three (3) months of employment while they are providing eligible services. This policy shall not supersede any professional practices act.

**Ongoing Supervision**

While providing services, non-LMHP staff shall receive face-to-face supervision and observation for a minimum of one (1) hour per month after completing the initial supervision period. The policy shall not supersede any professional practices act.

**NOTE:** A new employee does not need to complete the initial supervision if there is documentation indicating that the required initial supervision was completed within the past twelve(12 )months. This applies only to employees who are rehired by the same provider or who transfer from another MHR provider.

Ongoing supervision and feedback from the licensed person actively directing the case shall occur on a routine basis to ensure:

- Provision of appropriate services specific to the ISRP;
- Provision of assistance to recipients in order to meet individual goals;
- Incorporation of recovery/resiliency and rehabilitation in all aspects of service delivery;
- Effective treatment;
- Assessment of progress;
- Proper reporting of significant issues including possible abuse, neglect extortion, exploitation, health and safety issues and crises

**Orientation and Training**

Orientation and training shall be provided to new staff member, subcontractor, volunteer, or intern.

- The provider shall develop, implement and maintain an orientation and ongoing training policy that conforms to the standards in the provider manual. All employees, volunteers, and students must receive orientation and training prior to providing services.
- Orientation training should be comprised of no less than five (5) face-to-face hours of training.



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- All orientation and training shall be documented in the employee's personnel record. The documentation shall include the date, title, class time (s), name and credentials of all trainers, and a dated, original signature of the trainee.
- Initial and ongoing training shall occur on a routine basis to ensure that the staff demonstrate competency in the areas identified in the MHR provider manual. Staff competency is evidenced by the staff person's ability to describe and apply the information obtained in the orientation and training. Ongoing training shall also be offered in response to service delivery issues identified through quality management activities.
- A new employee does not need to complete orientation training if there is documentation indicating that training was completed within the past twelve (12) months. This applies to employees who are rehired or who transfer from another provider.
- The backup staff must meet the orientation and training requirements outlined below who are providing backup support, with the exception of psychiatrist. The Backup psychiatrist must complete the orientation listed below within forty (40) hours of direct services.
- The medical staff, including the psychiatrist, APRN/CNS, NP, RN and LPN, may substitute review of a Bureau-approved training packet in lieu of the required sixteen (16) hours of orientation. The RN and LPN are only allowed to make the substitution for the sixteen (16) hours of orientation if medication management is the only service they will provide.
- Orientation is not billable.

**CHAPTER 31: MENTAL HEALTH REHABILITATION**

**SECTION 31.5: STAFFING AND TRAINING**

**Orientation and Training Hours**

Type	Must be Completed	Duration
Orientation – any staff member, subcontractor, volunteer or intern	Prior to providing service for which billing will be submitted	16 hours
On-the-job training (Non-LMHP staff only)	Prior to providing service for which billing will be submitted	16 hours
Rating the LOCUS and CALOCUS (ACE staff only)	Prior to conducting an initial or reassessment	6 hours
Other required training (any staff member, subcontractor, volunteer, or intern)	Within the first 60 days of employment	Varies
Job specific training	Annually	See details below

**Orientation On-Site Instructions**

The following training must be completed prior to providing services for which billing will be submitted. Sixteen (16) hours of on-site instruction includes all of the following content areas:

- Confidentiality,
- Protection of rights and reporting of violations,
- Abuse and neglect policies and procedures,
- Emergency and safety procedures,
- Infection control procedures,
- Agency policies and procedures,
- Ethics, including advertising and solicitation,
- Basic information about mental illness,
- Developing and implementing behavioral interventions,
- Skills training (specific teaching methods and methods to track consumer progress),
- Linking and coordinating natural and community supports,
- Crisis intervention,

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- Suicide and homicide precaution procedures,
- Developing effective service plans including goals using “SMART” (Specific, Measurable, Action-Oriented, Realistic, and Time-Limited),
- Person and family centered services,
- Prevention of workplace violence,
- Expectations regarding professional conduct, and
- Recipient rights.

Recipients and/or family members may be used as instructors or assistants for up to two (2) hours of training.

**On-the-Job Training**

Non-LMHP staff must be provided with at least sixteen (16) hours of on-the-job training, which involves observing and assisting a trained staff member in the delivery of services. Initial supervision as described earlier in this Section begins the first week after completed on-the-job training.

The following training must be completed prior to an LMHP conducting and billing for an initial assessment or reassessment.

**LOCUS and CALOCUS Training**

This training must be completed within the first sixty (60) days of employment.

**Other Required Training**

- Prior to handling or managing crisis calls unlicensed person employed by the provider shall have at least six (6) hours of documented training in Crisis Prevention Intervention (CPI) using a recognized training curriculum. The trainer must have documented experience in teaching and utilizing CPI intervention techniques consistent with state and federal laws. This training must be updated annually.
- Cultural competency training designed to achieve respect for cultural differences and cultural proficiencies related to the populations served by the provider.
- First aid, cardiopulmonary resuscitation (CPR) and seizure assessment.
- Implementation of a behavior management plan.

**NOTE:** Psychiatrist, APRN/CNS, NP, and RN, and LPN are exempt from first aid and seizure assessment training.

**NOTE:** Supervision as previously defined in this provider manual is not considered training.

**CHAPTER 31: MENTAL HEALTH REHABILITATION****SECTION 31.5: STAFFING AND TRAINING****PAGE(S) 14****Job Specific Training**

Employees who provide services to the targeted groups shall have training, experience working with these groups, and receive supervision from a staff member with specialized training and experience. All staff providing direct services for a PSR program must have documented training related to the psychosocial rehabilitation model(s) utilized in the program.

All employees, except the psychiatrist, shall receive annual training specifically related to his or her job duties. The provider must furnish and/or arrange for competency-based training to personnel rendering direct services based on needs identified through quality management and supervision:

**Annual Training**

LMHP and MHP staff – twenty (20) hours

MHS staff - thirty (30) hours

Online training is an approved method of instruction. The provider must ensure the content is competency based and meets the needs identified through quality management and supervision. Training content must be available at the request of the Bureau.

**Qualified Trainers**

Training shall be provided by persons with documented knowledge of the training topic and of the seriously mentally ill and/or emotionally/behaviorally disordered populations. Recipients and family members of persons with serious mental illness or serious emotional behavior disorder may provide training as is appropriate to their experience and knowledge.

**Bureau Training**

The provider staff must attend and participate in all trainings and meetings mandated by the Bureau.

## 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:

The Office of Mental Health  
Attn: Network Services  
1885 Wooddale Blvd., 9<sup>th</sup> Floor  
Baton Rouge, LA 70806  
Fax: 225-925-4789 or 225-925-4790

**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 31.6: RECORD KEEPING****PAGE(S) 6**

The provider must safeguard the confidentiality of any information, which may identify the recipients or their families. The information may be released only under the following conditions:

- By a court order,
- By the recipient's written, informed consent for release of information,
- If the recipient has been declared legally incompetent, his/her legal representative must provide written consent, or
- If the recipient is a minor, the parent or legal guardian must provide written consent, or

Upon request, a provider must make available information in the recipient records to the recipient, legally responsible guardian, or other service providers including another MHR provider in the case of a recipient transfer. If, in the professional judgment of the provider, information contained in the record would be harmful to the recipient, that information may be withheld from him/her except under court order.

A provider may use material from recipient records for educational purposes if names are deleted and other identifying information is removed. For research purposes, providers must comply with the Bureau's research policy (refer to Appendix C), which is posted on the MHR website, [www.mhrsla.org](http://www.mhrsla.org).

**NOTE:** Under no circumstances should providers allow staff to remove recipient records from the provider's site.

**Review by State and Federal Agencies**

Providers must make all administrative, personnel and recipient records available to the Bureau and appropriate state and federal personnel upon request. Failure to allow access to records in a timely manner may result in a sanction.

**Administrative and Personnel Records**

The provider's administrative files must have critical program information including but not limited to documentation of Medicaid enrollment, insurance policies, minutes of formal meetings, bylaws of the governing body, if applicable, training and supervision documentation, and required policies and procedures as detailed in Section 31.5.

Personnel records shall be maintained for all staff, subcontractors, volunteers and interns. The record must contain all documents detailed in Section 31.5 Staffing and Training-Personnel Records). An employee must have reasonable access to his/her personnel file and must be allowed to include any written statement he/she wishes in the file.

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A provider must not release a personnel file without the employee's written permission except according to state law.

**Recipient Records**

Records must be maintained in chronological order. Documentation shall be sufficient to verify that services conform to the Bureau policy as stated below and that the reimbursement amount is correct.

The organization of individual records and location of documents must be uniform. Records must be appropriately thinned so that current material can be easily located. Records must contain at least six (6) months of current pertinent information relating to services provided. Records older than six (6) months must be kept on-site and be available for review upon the request of the Bureau.

All entries and forms completed by staff in recipient records must be:

- In ink, in a color other than black,
- Legible,
- Fully dated,
- Legibly signed, and
- Include the functional title of the individual making the entry.

Any error in a recipient's record must be corrected using the legal method, which is to draw a line through the incorrect information, write "error" by it and initial the correction. **Correction fluid must never be used in a recipient's records.** If information is typed, signatures must be in ink, in a color other than black.

**Components of Recipient Records**

The recipient's record must consist of the active recipient record and stored files or folders. The active record must contain the following current information unless a recipient refuses disclosure, which may include race, ethnic origin, sex, or marital status.

Identifying information recorded on a standardized form including the following:

- Name,
- Home address,
- Home telephone number,
- Date of birth,
- Sex,
- Race or ethnic origin,

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- Living arrangements,
  - Closest living relative/guardian,
  - Education,
  - Marital status,
  - Name, address, and telephone number of employer or school,
  - Date of initial contact,
  - Court and/or legal status, including relevant legal documents,
  - Names, addresses, and telephone numbers of other involved with the recipient's ISRP,
  - Date this information was gathered,
  - Required signatures on all forms, and
  - Signed release of information form.
- 
- Documentation verifying that the recipient meets medical necessity criteria including copies of required professional evaluations, past treatment records, LOCUS/CALOUS rating, the MHR screening form, the MHR initial and reassessment reports, and other reports and information concerning the recipient's medical, social, familial, cultural, developmental, legal, educational, vocational, psychiatric and economic status.
  - Electronic clinical data inquiry printout.
  - Medicaid eligibility information for Medicaid recipients.
  - A copy of the Freedom of Choice form, confidentiality information, complaint procedures, etc. signed by the recipient.
  - A completed and signed ISRP including the crisis plan and discharge plan.
  - Reason for case closure and any agreements with the recipient at closure.
  - Service logs.
  - Copies of all pertinent correspondence.
  - If the provider is aware that a recipient has been interdicted, a statement to this effect must be noted and the court appointed guardian named.
  - A description of any current treatment or medication necessary for the treatment of any serious or life threatening medical condition or known allergies. This may include documentation from the treating physician.



**CHAPTER 31: MENTAL HEALTH REHABILITATION****SECTION 31.6: RECORD KEEPING****PAGE(S) 6****Service Logs**

Service logs document the allowable services billed and must reflect the services delivered. To obtain a copy of the service log, refer to Appendix D. They will be reviewed during recertification, monitoring, and when deemed necessary by the Bureau. Record entries must correspond with the services provided including billable services entered into the statewide data system as well as non-billable services.

Non-billable services, such as team planning or services provided during a lapse in authorizations must be documented on a service log with the statement “Non-billable Service” written at the top of the log. Federal and state requirements for documenting claims require that the following information must be entered on the service log:

- Service log number,
- Name of recipient,
- Name of provider and employee providing the service,
- Date of service contact,
- Begin and end time for service rendered,
- Indication if a crisis occurred during the contact,
- Place of service contact,
- Type of contact,
- Service provided,
- Service Participants, and
- Narrative describing the service.

Service logs must include specific documentation instead of using general terms such as "assisted recipient to" and "supported recipient" do not constitute adequate documentation. When more than one service is provided to a recipient during a contact, a service log must be completed for each service. For each log entry, the goal, objective, and intervention as documented in the ISRP must be paraphrased. The use of goal, objective, and intervention numbering is not acceptable. For example, “Goal 1, Objective 1, Intervention 1” does not constitute acceptable documentation. All of the following documentation components must be included for each log entry:

- Goals, objectives, and interventions documented in the recipient’s current ISRP. If crisis services are provided, the ISRP must be updated to reflect the needed services.
- Services are appropriate in terms of frequency and intensity.
- Services are clinically appropriate to the needs of the recipient.

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- Specific intervention (s) and training material used during the contact.
- Recipient's response to interventions using observable/behaviors terms.
- Recipient's progress with accomplishing the targeted goal or objective.
- A plan for the next recipient contact to ensure continuity of services.
- Specific location when services are provided in the community.

Only the staff member providing the services may develop, sign, and make any necessary corrections to the service log. Service logs must be completed at or near the time of service to ensure accuracy.

Services logs must be reviewed and signed by the supervisor on a regular basis to ensure that all activities are appropriate, relative to the service type, location, service participant and duration and that documentation is sufficient to indicate progress towards achievement of treatment goals. Supervision is not billable.

## **PROGRAM MONITORING**

The Bureau will monitor providers to ensure services comply with program standards. It is the provider's responsibility to be knowledgeable regarding the policies and procedures governing the program. Non-compliance may result in the recoupment of Medicaid payments, administrative sanctions and/or a referral to the appropriate state and/or federal authorities for further investigation, which may result in additional punitive action.

The Bureau may conduct a monitoring review for reasons including but not limited to ensuring compliance with program requirements, reviewing billing practices and investigating complaints and grievances.

### **Monitoring**

A monitoring review may include a review of the following:

- Recipient records,
- Personnel records,
- Administrative records,
- Provider profile data,
- MHRISIS/Utopia data reports,
- Accreditation reports,
- Staff and recipient interviews, and
- Any other requested data or files.

### **Interviews**

Monitoring interviews may include interviews with the following:

- A representative sample of the recipients,
- An adult recipient's family and friends, if the recipient approves,
- A child's family, friends, teacher and other school personnel, with the approval of the parent or guardian, and/or
- Current or former staff

### **Monitoring Results**

Upon completion of a monitoring review, the Bureau staff may conduct an exit interview to discuss the findings. A written report summarizing the findings will be sent to the provider, stating whether a plan of correction is required.

**CHAPTER 31: MENTAL HEALTH REHABILITATION****SECTION 31.7: PROGRAM MONITORING****PAGE(S) 2****Plan of Correction**

A plan of correction (POC), if required, must be submitted to the Bureau. If the POC is not submitted within ten (10) working days, sanctions as described in Section 31.8 and Chapter 6 of the Medicaid Provider Manual may be applied. The POC must address the correction of each deficiency cited. If the POC submitted does not meet Bureau standards, it may be returned to the provider for revision.

All deficiencies must be corrected within sixty (60) days of receipt of the notice. Failure to do so may result in sanctions. A follow-up review may be conducted by the Bureau to ensure that all deficiencies have been corrected.

### ADMINISTRATIVE SANCTIONS

Administrative sanctions may be imposed against a provider that does not meet the requirements as established in laws, rules, regulations or policies. This section explains the administrative actions and sanctions as they apply to a MHR provider. In addition, sanctions cited in Chapter 6 of the Medicaid Services Provider Manual and the Surveillance and Utilization Systems (SURS) rule, LAC 50:1 Chapter 41 (Louisiana Register, Volume 29, Number 4) may be imposed.

The following sanctions may be applied to any provider independently, consecutively and/or collectively.

- The provider's staff may be required to complete education and training, including training in MHR policy and billing procedures provided by DHH. The provider may also be required to obtain other education or training relevant to providing quality MHR services, such as psychosocial skills training, individual counseling, etc. which the Bureau will not provide.
- Payments for services rendered may be suspended or withheld until program compliance is verified.
- The provider may be terminated and all service authorizations canceled. Terminated providers, including all of the owners, officers, or directors may not apply for certification as an MHR provider for a period of up to five years. The provider must assist the recipient in locating other services.
- New requests for service authorization or reauthorizations may be denied until program compliance is verified.
- The provider's current recipients shall be transferred to another provider if the Bureau determines that recipient health and safety are compromised. In the absence of an available provider, the recipient may be referred to an alternate treatment source.
- Individuals employed by the provider may be suspended or excluded from providing MHR services.

**NOTE:** Health and safety issues will be resolved on a case-by-case basis by Bureau personnel making a determination after examining the circumstances surrounding each particular event or finding. The Bureau is allowed the flexibility to explore fully any circumstances surrounding each unique situation to ensure that the well-being of the recipient and the integrity of the Medicaid Program are protected.

**CHAPTER 31: MENTAL HEALTH REHABILITATION****SECTION 31.8: ADMINISTRATIVE SANCTIONS PAGE(S) 4****Grounds for Sanctioning Providers**

The following are grounds for sanctioning of an MHR provider:

- Failure to comply with any and all certification, administrative, accreditation, training or operational requirements at any time;
- Failure to provide the full range of services specified in the recipient's service agreement;
- Failure to uphold recipients' rights when violations may or could result in harm or injury;
- Failure to notify proper authorities of all suspected cases of neglect, criminal activity, or mental or physical abuse which could potentially cause, or actually causes harm to the recipient;
- Failure to maintain adequate qualified staff to provide necessary services;
- Failure to adequately document services billed were actually performed;
- Failure of a MHR provider's subcontractors to meet all required standards;
- Failure to fully cooperate with a Bureau survey or investigation including, but not limited to failure to allow Bureau staff entry to the provider's or subcontractor's offices or denial of access to any requested records during any survey or investigation;
- Failure to comply with all reporting requirements in a timely manner;
- Failure to provide documentation that verifies compliance with any requirement as set forth in this policy;
- Failure to comply with any or all federal and state laws, rules and regulations, the provider manual and any other notices or directives issued by the Bureau;
- Failure to protect recipients from harmful actions of a MHR provider's employees or subcontractors including but not limited to health and safety, coercion, threat, intimidation, solicitation or harassment;
- Failure to remain fully operational at all times for any reason other than a natural disaster;
- A substantial pattern of consistent complaints filed against a MHR provider, within a one (1) year period;
- A false statement of a material fact knowingly (or with reason to know) made by an owner or staff person of the MHR provider in the following areas;
  - An application for enrollment;
  - Data forms;
  - A recipient's record;
  - Any matter under investigation by the Bureau; or
  - Certification/recertification or the accreditation process.

**CHAPTER 31: MENTAL HEALTH REHABILITATION****SECTION 31.8: ADMINISTRATIVE SANCTIONS PAGE(S) 4**

- 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:

The Office of Mental Health  
1885 Wooddale Blvd., 9<sup>th</sup> Floor  
Baton Rouge, LA 70806  
Fax: 225-925-4789 or 225-925-4790

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.

**Notice and Appeal Procedure**

A provider that contests any adverse action taken by the Bureau may appeal such action by submitting a written request for an appeal to the Department's Bureau of Appeals. The request must be received by the Bureau of Appeals within thirty (30) days of the provider's receipt of the written notification of the Bureau's action. The appeal should be sent to the following address:

Bureau of Appeals  
Department of Health and Hospitals  
P O Box 4183  
Baton Rouge, LA 70821-4183

Sanctions in the form of a termination based on fraud and abuse or health and safety shall take effect immediately upon notice by the Bureau.

In cases not involving health and safety or program integrity issues where fraud or abuse is at issue, a sanctioned provider who has timely filed an appeal shall be allowed to accept new recipients during the appeals process unless the appeal is delayed beyond ninety (90) days due to action on the part of the provider. If the appeal is delayed beyond ninety (90) days due to action on the part of the provider, the provider may be prohibited from taking on new recipients until a ruling on the appeal has been issued.



## **FINANCIAL REIMBURSEMENT**

### **General Provisions for Reimbursement**

A particular service shall be excluded from coverage if it is determined to be the legal liability of any third party who is or may be liable to pay the expenditure for that service.

Services determined to be duplicate will not be reimbursed. Therefore, providers must not bill Medicaid for MHR services at the same time they bill another funding source for the same service. Duplicate claims will be denied and may be considered fraud and referred to the Program Integrity Section for further action.

When a recipient is admitted to an institution or hospital, the provider may bill for services provided up to the time of admission. The provider may resume billing for services after the recipient is discharged from the institution or hospital. No services can be billed while the recipient is in an inpatient facility.

The creation and transfer of information files and the submission of claims are related but separate processes. Providers are responsible for submitting claims to the fiscal intermediary (FI) in a timely manner. Any questions regarding a claim should be addressed to the FI Provider Relations Unit.

### **Information Transfer/Billing Schedule**

To ensure the timely payment of claims, the procedures outlined below should be followed:

- Enter data on MHRIS daily.
- Create and send an information file daily before 2:30 p.m. to Statistical Resources, Inc. (SRI). If a file is received after 3:00 p.m., it will not be processed until the next business day.
- Bill for services at least two (2) working days after submission of information to SRI.

### **Documentation Requirements**

Payment decisions are often made based on information contained in the recipient's record. If these records are not properly documented, incorrect payments may be made and overpayments will be recouped. In some cases, providers may be investigated for fraudulent billing.

**CHAPTER 31: MENTAL HEALTH REHABILITATION****SECTION 31.9: FINANCIAL REIMBURSEMENT PAGE(S) 2**

Proper documentation for MHR services includes:

- Documentation of medical necessity for MHR services.
- The MHR initial assessment and reassessments.
- The ISRP includes specific goals and objectives that are individualized and developed using SMART criteria (Specific, Measurable, Attainable, Realistic, and Time Limited).
- Service logs for services provided which are related to the ISRP and deemed medically necessary.

**ACRONYMS/DEFINITIONS**

**ACE-** Approved Clinical Evaluator

**ACGME-** Accreditation Council for Graduate Medical Education

**ADA-**American Disability Act

**AG** – Attorney General

**Affidavit-** A written statement of facts made voluntarily and under oath.

**APRN** - Advanced Practice/Registered Nurse

**Bureau/BHSF** - Bureau Health Services Financing (or its designee)

**Board Eligible** - A physician who provides psychiatric services that holds an unrestricted license to practice medicine in Louisiana. If licenses are held in more than one state or jurisdiction, all licenses held by the physician must be documented in the employment record and be unrestricted. In addition, the physician must have satisfactorily completed a specialized psychiatric residency training program accredited by the Accreditation Council for Graduate Medical Education (ACGME), as evidenced by a copy of the certificate of training or a letter of verification of training from the training director, including exact dates of training and verification that all ACGME requirements have been satisfactorily met. If training was completed in child and youth psychiatry, the training director of the child and youth psychiatry program must document the child and youth psychiatry training. All documents must be maintained and readily retrieved for review by the Bureau or its designee.

**CALOCUS** – Children/Adolescent Level of Care Utilization Scale

**CARF** - Commission on Accreditation of Rehabilitation Facilities

**CASSP-** Child and Adolescent Service System Program

**CBT-** Cognitive-Behavioral Therapy

**CEU** - Continuing Education Unit

**CHOW-** Changes in Ownership

**CMHC-**Community Mental Health Clinic

**CHAPTER 31: MENTAL HEALTH REHABILITATION**

**SECTION 31.10: ACRONYMS/DEFINITIONS**

**CMS** – Center for Medicare/Medicaid Services

**CNS** - Clinical Nurse Specialist

**COA** - Council on Accreditation

**Core Mental Health Disciplines**—Academic training programs in psychiatry, psychology, counseling, social work and psychiatric nursing.

**CPRP** – Certified Psychosocial Rehabilitation Practitioner as designated by the Commission for Psychiatric Rehabilitation Certification through the United States Psychiatric Rehabilitation Services Association (USPRA)

**CS** – Community Support

**CSW** – Community Support Worker

**Department/DHH**—Department of Health and Hospitals

**DSS** – Department of Social Services

**e-CDI**- Electronic Clinical Data Inquiry

**Evidence Based**- A clinical intervention, which has been consistently shown in several research studies to assist recipients in achieving their desired goals of health and wellness.

**FBI** – Federal Bureau of Investigation

**FI** – Fiscal Intermediary

**FINS**- Family In Need of Supervision

**Governing Body**— The organizers, incorporators, shareholders and board of directors of a MHR provider; and the principal licensed and professional employees who manage, oversee and administer the day-to-day operation of an MHR provider

**HIPAA** – Health Insurance Portability and Accountability Act

**ISRP** – Individualized Service and Recovery Plan

**JCAHO** - Joint Commission on Accreditation of Healthcare Organizations

**CHAPTER 31: MENTAL HEALTH REHABILITATION****SECTION 31.10: ACRONYMS/DEFINITIONS****PAGE(S) 6**

**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

**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

**OMH** - Office of Mental Health

**CHAPTER 31: MENTAL HEALTH REHABILITATION****SECTION 31.10: ACRONYMS/DEFINITIONS****PAGE(S) 6**

**OPH** – Office of Public Health

**Off-site Service Delivery Location** - Locations of service that are publicly available and commonly used by, members of the community other than the provider (e.g. libraries, community centers, YMCA, church meeting rooms, etc.) and sites or locations that are directly related to the recipient's usual environment, (e.g. home, place of work, school). Other off-site service locations are those sites or locations that are utilized in a non-routine manner (e.g. hospital emergency room or any other location in which a crisis intervention service is provided during the course of the crisis). This can also include a location used solely for the provision of allowable off-site service delivery by a certified MHR provider.

However, any such location must not be staffed by the provider at times when services are not being provided, must not house any records of the provider, or be a place where the provider routinely conducts business but for the allowable off-site service delivery. These locations are allowed for delivery of the restructured MHR program.

Group counseling and PSR Group 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.

Medication Management may be provided at the approved provider site or in a recipient's natural environment (schools, home, etc.) as appropriate to recipient needs and circumstances and in compliance with privacy and confidentiality requirements.

Services may not be provided in an individual practitioner's private office. Service may not be provided in the home of employees or agents of the provider.

**On-site** – Location of MHR facility that is licensed and certified by the appropriate state agency or accreditation body to provide specific services.

**OSHA** – Occupational Safety Health and Administration

**Overpayment** - Any amount paid by the Bureau to an MHR provider that exceeds the amount allowed for a service or services furnished under the Medicaid Program. The provider shall reimburse the Bureau for overpayments.

**OJJ** -Office of Juvenile Justice Development (*formerly Office of Youth Development*)

**PA** – Prior Authorization

**PFII** – Parent/Family Intervention – Intensive

**CHAPTER 31: MENTAL HEALTH REHABILITATION**

**SECTION 31.10: ACRONYMS/DEFINITIONS**

**POC** – Plan of Correction

**Program Integrity Section** – The section of the Bureau responsible for investigating allegations of fraud and abuse.

**Provider Contract** – an agreement between the Bureau and a MHR provider.

**PSR** – Psychosocial Skills Training Group

**PSR Models (for Adults)** - Boston Psychiatric Rehabilitation Model, Clubhouse Model and Social Skills Training Model

**QMP** – Quality Management Program

**Recipient** – A person who is Medicaid eligible and receiving MHR services

**RECON** - Reconsideration

**Recoupment** - The Bureau’s authority to recover payments made for services that are subsequently determined not to qualify for reimbursement.

**RN** – Registered Nurse

**Repayment** -The MHR provider’s obligation to refund payments to the Bureau for any claims that are determined not to qualify for reimbursement

**SAA** – Service Access and Authorization

**SAMHSA** - Substance Abuse and Mental Health Services Administration

**Service Area** - The restricted geographical area delineated by the Bureau in which the MHR provider may offer services. **SMART** - Specific, Measurable, Action-Oriented, Realistic and Time-Limited

**SPOE** - Single Point of Entry

**SRI** – Statistical Resources, Inc.

**SURS** - Surveillance and Utilization Review Section

**TB** – Tuberculosis

**UNISYS Corp.** – The agency contracted by the Bureau to act as fiscal intermediary

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**CHAPTER 31: MENTAL HEALTH REHABILITATION**

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**SECTION 31.10: ACRONYMS/DEFINITIONS**

**USPRA** - United States Psychiatric Rehabilitation Association

**UTOPIA** – Utilization, Tracking, Oversight, and Prior Authorization Information System

**WRAP** – Wellness Recovery Action Plan