Revision Details to Section 2.0 Overview of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

January 2021

Added language that applies across services pertaining to provider's responsibilities.
Publication date: 1/5/21

All mental health services must be medically necessary in accordance with LAC 50:I.1101. The medical necessity for services shall be determined by a licensed mental health professional (LMHP) or physician who is acting within the scope of their professional license and applicable state law. There shall be member involvement throughout the planning and delivery of services.

Services shall be:

- Delivered in a culturally and linguistically competent manner;
- Respectful of the individual receiving services;
- Appropriate to individuals of diverse racial, ethnic, religious, sexual and gender identities and other cultural and linguistic groups; and
- Appropriate for age, development; and education.

March 2020

Added language to clarify LDH's and provider's responsibilities regarding the manual.
Publication date: 3/30/20

The Louisiana Department of Health (LDH) strives to make the information in this manual chapter as accurate, complete, reliable and as timely as possible. This manual chapter is subject to change as the implementation and operations of specialized behavioral health services continue to evolve. Providers are responsible for ensuring services are delivered in accordance with this manual and compliant with any authorities in effect on the date of service. Prior to inclusion of behavioral health services in this Medicaid Service Provider Manual in 2017, the Service Definition Manual version 9 (SDM v9) was in effect. Providers must ensure services are delivered in accordance with the Medicaid Service Provider Manual and any other authorities in effect on the date of service.

LDH, its employees, agents, or others will not be liable or responsible for any claim, loss, injury, liability, or damages related to your use of, or reliance upon this information.

This information is not intended to be a substitute for professional legal, financial or business advice. This manual does not create, nor is it intended to create, an attorney-client relationship between you and LDH. You are urged to consult with your attorney, accountant or other qualified professional if you require advice or opinions tailored to your specific needs and circumstances.

Revision Details to Section 2.1 Provider Requirements of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

June 2018

Revision made to page add note relevant to specialized behavioral health providers and the Healthy Louisiana Medicaid Managed Care Program/Coordinated System of Care (CSoC) Contractor. Clarified that not all behavioral health providers are enrolled with Medicaid.
Publication date: 6/29/18

PROVIDER REQUIREMENTS

~~A provider must be enrolled in the Medicaid Program and meet the provider qualifications at the time service is rendered to be eligible to receive reimbursement through the Louisiana Medicaid Program.~~

All providers must meet the provider qualifications at the time service is rendered to be eligible to receive reimbursement directly from Medicaid or from a Medicaid managed care contractor. Providers must also be enrolled in Medicaid in order to be reimbursed when rendering and billing for services to recipients in Medicaid's Fee for Service program (non-Managed Care), or to Medicaid recipients that are dually enrolled in Medicare and are receiving Medicare eligible services. For more information regarding billing for specialized behavioral health services for dual eligible members, refer to LDH Information Bulletin 15-17 posted at http://ldh.la.gov/index.cfm/page/1198.

Revision Details to Section 2.2 Bed Based Services of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

Section 2.2 ~~Residential~~ Bed Based Services – Psychiatric Residential Treatment Facilities

January 2021

Revisions made to restructure and revise current criteria and incorporate new PTRF service criteria as a new sub-section of Bed Based Services.

Publication date: 1/5/21

Provider Responsibilities

Facilities must use evidence-based or best practice clinical techniques as part of their program model. For milieu management, all programs should also incorporate some form of research-based, trauma-informed programming and training. A PRTF specializing in substance use disorder treatment must comply with ASAM criteria. PRTF may specialize and provide care for maladaptive sexual behaviors, substance use treatment or individuals with co-occurring disorders. If a program provides care to any of these categories of youth, the program must submit documentation regarding the appropriateness of the research-based, trauma-informed programming and training, as well as compliance with the ASAM level of care being provided.

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

The specific research-based models to be used should be incorporated into the program description, which should include information on the program's plan to ensure training for their staff in the selected research-based model(s), which staff types (direct care staff, therapists, etc.) are trained in the selected research-based model(s), and provisions for continuing education in the research-based model(s). All research-based programming in PRTF settings must be incorporated into the program description and approved by the State, subject to OBH review.

Provider Qualifications

Agency

- Arranges for and maintains documentation that prior to employment (or contracting, volunteering, or as required by law) individuals pass criminal background checks, including sexual offender registry checks, in accordance with all of the below:
  - The Psychiatric Residential Treatment Facilities ~~Behavioral Health Service Provider (BHSP)~~ licensing regulations established by the Louisiana Administrative Code (LAC) 48:I.Chapter 90, which includes those for owners, managers, and administrators;
  - La. R.S. 40:1203.1 et seq. associated with criminal background checks of un-licensed workers providing patient care;
  - La. R.S. 15:587, as applicable; and
  - Any other applicable state or federal law.
- Providers shall not hire individuals failing to meet criminal background check requirements and regulations. Individuals not in compliance with criminal background check requirements and regulations shall not be utilized on an employment, contract nor volunteer basis. Criminal background checks performed over 90 days prior to the date of employment will not be accepted as meeting the criminal background check requirement. Results of criminal background checks are to be maintained in the individual's personnel record.
- ~~Arrange for criminal background checks and maintain documentation for any applicant for employment, contractor, volunteer and other person who will provide services to the residents prior to that person working at the facility. If the results of any criminal background check reveal that the potential employee, volunteer or contractor was convicted of any offenses against a child/youth or an elderly or disabled person, the provider must not hire and/or must terminate the employment (or contract) of such individual. The provider must not hire an individual with a record as a sex offender nor permit these individuals to work for the provider as a subcontractor. Criminal background checks must be performed as required by R.S. 40:1203 et seq., and in accordance with R.S. 15:587 et seq. Criminal background checks performed over 30 days prior to the date of employment will not be accepted as meeting this requirement;~~
- The provider must review the Department of Health and Human Services' Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) and the LDH State Adverse Actions website prior to hiring or contracting any employee or contractor that performs services that are compensated with Medicaid/Medicare funds, including but not limited to licensed and unlicensed staff, interns and contractors. Once employed, the lists must be checked once a month thereafter to determine if there is a finding that an employee or contractor has abused, neglected or extorted any individual or if they have been excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General. The provider is prohibited from knowingly employing or contracting with, or retaining the employment of or contract with, anyone who has a negative finding placed on the Louisiana State Adverse Action List, or who have been

excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General.

- Providers are required to maintain results in personnel records that checks have been completed. The OIG maintains the LEIE on the OIG website (https://exclusions.oig.hhs.gov) and the LDH Adverse Action website (https://adverseactions.ldh.la.gov/SelSearch);
- ~~The PRTF is also restricted from knowingly employing and/or contracting with a person who has a finding placed on the Louisiana State Nurse Aide Registry or the Louisiana Direct Service Worker Registry;~~

Staff

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

- Employees and contractors must not be excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General;
- Direct care staff must not have a finding on the Louisiana State Adverse Action List;
- Complete American Heart Association (AHA) recognized First Aid and CPR ~~and seizure assessment training~~. Psychiatrists, advanced practical registered nurses (APRNs)/clinical nurse specialists (CNSs)/physician assistants (PAs), registered nurses (RNs) and licensed practical nurses (LPNs) are exempt from this training. (See Appendix D of this manual chapter); and

Section 2.2 ~~Residential~~ Bed Based Services – Therapeutic Group Homes

January 2021

Revisions made to restructure and revise current criteria and incorporate new TGH service criteria as a new sub-section of Bed Based Services.

Publication date: 1/5/21

Program Requirements

All programs should incorporate some form of research-based, trauma-informed programming and training. For clinical intervention, the program must incorporate at least one research-based approach pertinent to the population of TGH members to be served by the specific program. All research-based programming in TGH settings must be approved by the State.

TGH facilities may specialize and provide care for sexually maladaptive behaviors, substance use or dually diagnosed individuals. If a program provides care to any of these categories of youth, the program must submit documentation as part of their program

description submitted to the State regarding the appropriateness of the research-based, trauma-informed programming and training, as well as compliance with the American Society of Addiction Medicine (ASAM) level of care being provided (if applicable).

The specific research-based model(s) to be used should be incorporated into the program description, including information on the program's plan to ensure training for their staff in the selected research-based model(s), which staff types (direct care staff, therapists, etc.) are trained in the selected research-based model(s), and provisions for continuing education in the research-based model(s). The program description should be submitted to the State for approval, subject to OBH review.

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

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

Staff

- Employees and contractors must not be excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General;
- Direct care staff must not have a finding on the Louisiana State Adverse Action List;
- ~~Must not have a finding on the Louisiana State Nurse Aide Registry and the Louisiana Direct Service Worker Registry against him/her;~~
- Complete American Heart Association (AHA) recognized First Aid, and CPR ~~and seizure assessment training~~. Psychiatrists, advanced practical registered nurses (APRNs)/clinical nurse specialists (CNSs)/physician assistants (PAs), registered nurses (RNs) and licensed practical nurses (LPNs) are exempt from this training. (See Appendix D of this manual chapter.)

Section ~~2.1~~ 2.2 Residential Services

June 2019

Clarified language pertaining to agency documentation protocol. Deleted the CSoC contractor from receiving documentation.

Published date: 6/12/19

Retro-active effective date: 12/1/15

Section 2.1 Residential Services

April 2018

Revisions made to the staffing requirements for psychiatric residential treatment facilities. Aligned staffing requirement for the PRTF to licensing rule requirements.

Publication date: 4/5/18

Effective upon publication of the licensing rule

Staffing Requirements (PRTF)

The provider must ensure that:

- ~~There is one FTE RN/LPN available on site 7am-11pm;~~
- There is one FTE RN/LPN available on duty on site at all times;
- There is a licensed or certified clinician or counselor with direct supervision by an LMHP, or unlicensed professional (UP) under supervision of a ~~QPS~~ clinical supervisor – ~~one clinician per eight clients~~ Caseloads not to exceed eight members;
- The facility shall maintain:
  - a minimum ratio of one staff person for four residents (1:4) between the hours of 6 a.m. and 10 p.m. The staff for purposes of this ratio shall consist of direct care staff (i.e. licensed practical nurse (LPN), MHS, MHP, LMHP, etc.).
  - a minimum ratio of one staff person for six residents (1:6) between 10 p.m. and 6 a.m. Staff shall always be awake while on duty. The staff for purposes of this ratio shall consist of direct care staff (i.e. LPN, MHS, MHP, LMHP, etc.). Louisiana Register Vol. 43, No. 02 February 20, 2017 330.
- ~~There is Direct care aide staff available - Two FTE PA's on all shifts. Ratio cannot exceed 1:8. Ratio must be 1:3 on therapy outings;~~

Revisions made to remove information concerning Level 3.7-WM Medically Monitored Residential Withdrawal Management – Adolescent. Removed 3.7WM PRTF as a service.

Publication date: 4/5/18

Revision Details to Section 2.3 Outpatient Services – Adult Crisis Response Services of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

February 2022

New chapter added to the manual.
Publication date: 2/24/22

Revision Details to Section 2.3 Outpatient Services – Individual Placement and Support (IPS) of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

February 2022

New chapter added to the manual.
Publication date: 2/21/22

Revision Details to Section 2.3 Outpatient Services – Rehabilitation Services of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

January 2022

Revisions made to Psychosocial Rehabilitation staff qualifications.

Publication date: 1/20/22

Psychosocial Rehabilitation
PSR Provider Qualifications
Staff

Staff shall operate under an agency license issued by LDH Health Standards. PSR services may not be performed by an individual who is not under the authority of an agency license.

To provide psychosocial rehabilitation services, staff must meet the following requirements:

1. Effective on or after January 1, 2022, any individual rendering PSR services for a licensed and accredited provider agency must meet the following qualifications:
    a. Have a bachelor's degree from an accredited university or college in the field of counseling, social work, psychology, sociology, rehabilitation services, special education, early childhood education, secondary education, family and consumer sciences, or human growth and development; or
    b. Have a bachelor's degree from an accredited university or college with a minor in counseling, social work, sociology, or psychology; or
    c. Be twenty-one (21) years of age or older as of January 1, 2022, have a high school diploma or equivalency, and have been continuously employed by a licensed and accredited agency providing PSR services since prior to January 1, 2019

~~Prior to January 1, 2019, staff must have been at least eighteen (18) years old and have had a high school diploma or equivalent. Effective on or after January 1, 2019, staff rendering PSR services must have a minimum of a bachelor's degree from an accredited university or college with a major in counseling, social work, psychology or sociology. This can include credentialed peer support specialists as defined by LDH who meet all~~

~~other qualifications to provide the service. Any individual rendering PSR services for a licensed and accredited agency who does not possess the minimum bachelor's degree required to provide PSR services, but who met the qualifications in effect prior to January 1, 2019, may continue to provide PSR services for the same provider agency. Prior to the individual rendering PSR services for a different provider agency, the individual must meet the new minimum requirements in effect.~~

June 2020

Revisions made to clarify treatment plan oversight.

Publication date: 6/20/20

Treatment Plan Oversight

The LMHP must review the treatment plan including the goals, objectives, interventions, places of service, and service participants to ensure each service contact increases the possibility that a member will make progress. To determine if updates are needed, the review must be in consultation with provider staff, the member/caregiver and other stakeholders at least once every 180 days or more often if indicated. The member record must include documentation of the treatment plan review.

The member shall receive a signed copy of the plan upon completion and after each revision. A copy of the treatment plan should also be sent to all of the individuals involved in implementing and monitoring the treatment plan. The treatment plan should not include services that are duplicative, unnecessary or inappropriate. ~~The treatment plan shall be reviewed at least once every 365 days or when there is a significant change in the individual's circumstances.~~

April 2020

Revisions were made to clarify Staff Supervision for Non-Licensed Staff

Publication date: 4/8/20

Staff Supervision for Non-Licensed Staff

- **Effective ~~June~~ July 15, 2020**, staff shall receive a minimum of **four (4)** hours of clinical supervision per month for full time staff and a minimum of **one** (1) hour of clinical supervision per month for part time staff, that shall consist of **no less than one (1) hour of individual supervision**. Each month, the remaining hours of supervision may be in a group setting. Given consideration of caseload and acuity, additional supervision may be indicated.

March 2020

Revisions were made to clarify provider qualifications and incorporate criteria for Staff Supervision for Non-Licensed Staff

Publication date: 3/30/20

Rehabilitation Services for Children, Adolescents and Adults

The following provisions apply to all rehabilitation services for children, adolescents and adults, which include the following:

- Community Psychiatric Support and Treatment;
- Psychosocial Rehabilitation;
- Crisis Intervention; and
- Crisis Stabilization (children and adolescents only).

These rehabilitation services are provided as part of a comprehensive specialized psychiatric program available to all Medicaid eligible children, adolescents and adults with significant functional impairments resulting from an identified mental health disorder diagnosis. The medical necessity for these rehabilitative services must be determined by and services recommended by a licensed mental health professional (LMHP) or physician, ~~or under the direction of a licensed practitioner,~~ to promote the maximum reduction of symptoms and restoration to his/her best age-appropriate functional level.

Service Delivery

Services may be provided at a facility, in the community, or in the individual's place of residence as outlined in the ~~plan of care (POC)~~ treatment plan. Services may be furnished in a nursing facility only in accordance with policies and procedures issued by the Department. Services shall not be provided at an institute for mental disease (IMD).

Assessment ~~and Treatment Planning~~

- ~~Treatment plans shall be based on the assessed needs, and developed by an LMHP or physician in collaboration with direct care staff, the member, family and natural supports, and shall contain goals and interventions targeting areas of risk and need identified in the assessment. All team members, including the member and family, shall sign the treatment plan. The member shall receive a copy of the plan upon completion.~~
- ~~The treatment plan shall be reviewed at least once every 365 days or when there is a significant change in the individual's circumstances.~~

Treatment Plan Development

Treatment plans shall be based on the assessed needs, and developed by an LMHP or physician in collaboration with direct care staff, the member, family and natural supports, and shall contain goals and interventions targeting areas of risk and need identified in the assessment. All team members, including the member and family, shall sign the treatment plan. The member shall receive a copy of the plan upon completion. (If the member is too young to sign the treatment plan, a caregiver signature is sufficient to sign and receive the treatment plan.)

The goal of the treatment plan is to help ensure measurable improved outcomes, increased strengths, a reduction in risk of harm to self or others, and a reduction in the risk of out of home placements to inpatient and residential care. Based on an assessment/reassessment and informed by the member, parent/caregiver, the written treatment plan must meet the following requirements below.

The treatment plan must include:

- Goals and objectives that are specific, measurable, action oriented, realistic, and time-limited;
- Specific interventions based on the assessed needs that must include reference to training material when delivering skills training;
- Frequency and duration of services that will enable the member to meet the goals and outcomes identified in the treatment plan;
- Services and interventions to support independent community living for transitioning adolescents and adults in the setting of his or her own choice and must support integration in the community, including opportunities to seek employment, engage in community life, control personal resources, and improve functional skills at school, home or in the community;
- Member's strengths, capacities, and preferences;
- Clinical and support needs that are indicated by a psychosocial assessment, Child and Adolescent Level of Care Utilization System (CALOCUS) or Level of Care Utilization System (LOCUS) rating, , and other standardized assessment tools as clinically indicated;
- Place of service(s) for each intervention;

- Staff type delivering each intervention;
- Crisis avoidance interventions including the identification of risk factors and barriers with strategies to overcome them, including individualized back-up plans; and
- Language written in a way that is clearly understandable by the member.

Treatment Plan Oversight

- The treatment plan shall be reviewed at least once every 365 days or when there is a significant change in the individual's circumstances.

Provider Responsibilities

- ~~Non-licensed staff must receive regularly scheduled supervision from a person meeting the qualifications of an LMHP with experience regarding the specialized mental health service. Supervision refers to clinical support, guidance and consultation afforded to unlicensed staff rendering rehabilitation services, and should not be confused with clinical supervision of bachelor 's or master 's level individuals pursuing licensure.~~
- Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR) services provided by staff (holding an individual National Provider Identifier) regardless of employment at multiple agencies shall be limited to a maximum combined total of twelve (12) reimbursable hours of CPST services and PSR services within a calendar day.
  - The twelve-(12) hour limitation shall not apply per individual behavioral
  - health services provider agency, rather it applies per individual rendering provider.
  - The twelve-(12) hour limitation shall not apply to evidence-based practices.
  - There is a maximum combined total of twelve (12) reimbursable hours of CPST services and PSR services unless any of the following conditions are met:
    - The medical necessity of the services is documented through the prior authorization approval for a Medicaid recipient receiving more than twelve (12) hours of CPST and PSR services;
    - The services are billed for a group setting and the total hours worked by an individual rendering provider does not exceed twelve (12) hours per calendar day; or
    - The services are billed for crisis intervention.

Staff Supervision for Non-Licensed Staff
Services provided by a non-LMHP must be provided under regularly scheduled supervision listed below and if applicable in accordance with requirements established by the practitioner's professional licensing board under which they are pursuing a license.

Non-licensed staff must receive regularly scheduled supervision from a person meeting the qualifications of an LMHP (excluding Licensed Addiction Counselors (LACs) per the Act 582). LMHP supervisors must have the practice-specific education, experience, training, credentials, and licensure to coordinate an array of mental and/or behavioral health services. Agencies may have more than one LMHP supervisor providing required supervision to non-licensed staff. However, the agency must designate one Clinical Supervisor to fulfill the roles and responsibilities established for the Clinical Supervisor position in the Core Staffing section above. An LMHP supervisor may act in the role of the provider agency's Clinical Supervisor if the individual is qualified to fulfill both roles.

- Supervision refers to clinical support, guidance and consultation afforded to non-licensed staff rendering rehabilitation services, and should not be replaced by licensure supervision of master 's level individuals pursuing licensure.

- **Effective June 15, 2020**, staff shall receive a minimum of **four (4)** hours of clinical supervision per month for full time staff and a minimum of **one** (1) hour of clinical supervision per month for part time staff, that shall consist of **no less than one (1) hour of individual supervision**. Each month, the remaining hours of supervision may be in a group setting. Given consideration of caseload and acuity, additional supervision may be indicated.

- The LMHP (excluding LACs) supervisor must ensure services are in compliance with the established and approved treatment plan.

- Group supervision means one LMHP supervisor (excluding LACs) and not more than six (6) supervisees in supervision session. Individual and group meetings may be telephonic or via a secure Health Insurance Portability and Accountability Act HIPAA compliant online synchronous videoconferencing platform. Texts and/or emails cannot be used as a form of supervision to satisfy this requirement.

- The supervision with the LMHP must:
  - Occur before initial services on a new member begin and, at a minimum, twice a month preferably every fifteen (15) days (except under extenuating or emergent circumstances that are reflected in the supervisory notes).

- Progress notes that are discussed in supervision must have the LMHP supervisor signature.
- Have documentation reflecting the content of the training and/or clinical guidance. The documentation must include:
  - Date and duration of supervision;
  - Identification of supervision type as individual or group supervision;
  - Name and licensure credentials of the LMHP supervisor;
  - Name and credentials (provisionally licensed, master's degree, bachelor's degree, or high school degree) of the supervisees;
  - The focus of the session and subsequent actions that the supervisee must take;
  - Date and signature of the LMHP supervisor;
  - Date and signature of the supervisees;
  - Member identifier, service and date range of cases reviewed; and
  - Start and end time of each supervision session.

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

Additional Adult Eligibility Criteria for Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR)
~~Member~~ Adults receiving CPST and/or PSR must have at least a level of care of three on the LOCUS.
~~Members~~ Adults must meet the Substance Abuse and Mental Health Services Administration (SAMHSA) definition of, serious mental illness (SMI) as evidenced by a rating of three or greater on the functional status domain on the Level of Care Utilization System (LOCUS) rating. In addition to having a diagnosable mental disorder, the condition must substantially interfere with, or limit, one or more major life activities, such as:

- Basic daily living (for example, eating or dressing);
- Instrumental living (for example, taking prescribed medications or getting around the community); and
- Participating in a family, school, or workplace.

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

~~Members receiving CPST and/or PSR must have at least a level of care of three on the LOCUS.~~

CPST/PSR/CI/CS Provider Qualifications
Agency

- Arranges for and maintains documentation that prior to employment (or contracting, volunteering, or as required by law) individuals pass criminal background checks, including sexual offender registry checks, in accordance with all of the below:
    - The Behavioral Health Service Provider (BHSP) licensing regulations established by the Louisiana Administrative Code (LAC) 48:I.Chapter 56, which includes those for owners, managers, and administrators; any individual treating children and/or adolescents; and any non-licensed direct care staff;
    - La. R.S. 40:1203.1 *et seq*. associated with criminal background checks of un-licensed workers providing patient care;
    - La. R.S. 15:587, as applicable; and
    - Any other applicable state or federal law.

- Providers shall not hire individuals failing to meet criminal background check requirements and regulations. Individuals not in compliance with criminal background check requirements and regulations shall not be utilized on an employment, contract nor volunteer basis. Criminal background checks performed over ninety (90) days prior to the date of employment will not be accepted as meeting the criminal background check requirement. Results of criminal background checks are to be maintained in the individual's personnel record.
- ~~Arranges for and maintains documentation that all persons, prior to employment, pass criminal background checks through the Louisiana Department of Public Safety, State Police. If the results of any criminal background check reveal that the potential employee (or contractor) was convicted of any offenses against a child/youth or an elderly or disabled person, the provider shall not hire and/or shall terminate the employment (or contract) of such 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. Criminal background checks must be performed as required by R.S. 40:1203.1 et seq., and in accordance with R.S. 15:587 et seq. Criminal background checks performed over 90 days prior to date of employment will not be accepted as meeting this requirement.~~

- The provider must review the Department of Health and Human Services' Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) and the LDH State Adverse Actions website prior to hiring or contracting any employee or contractor that performs services that are compensated with Medicaid/Medicare funds, including but not limited to licensed and non-licensed staff, interns and contractors. Once employed, the lists must be checked once a month thereafter to determine if there is a finding that an employee or contractor has abused, neglected or extorted any individual or if they have been excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General. The provider is prohibited from knowingly employing, contracting with, or retaining the employment of or contract with, anyone who has a negative finding placed on the Louisiana State Adverse Action List, or who have been excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General.

  Providers are required to maintain results in personnel records that checks have been completed. The OIG maintains the LEIE on the OIG website (https://exclusions.oig.hhs.gov) and the LDH Adverse Action website is located at https://adverseactions.ldh.la.gov/SelSearch;

Staff

- Satisfactory completion of criminal background check pursuant to the BHSP licensing regulations (LAC 48:I. Chapter 56), La R.S. 40:1203.1 *et seq*., La R.S. 15:587 (as applicable), and any applicable state or federal law or regulation; ~~Pass criminal background check through the Louisiana Department of Public Safety, State Police prior to employment.~~

- Employees and contractors must not be excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General;

- Direct care staff must not have a finding on the Louisiana State Adverse Action List;

CPST Agency

- Effective May 31, 2018, must be credentialed and participating (contracted) in the provider network of the Medicaid managed care entity to be eligible to receive Medicaid reimbursement unless the provider agency is licensed and accredited,

and has an executed single case agreement with the Medicaid managed care entity.

- ~~Effective May 31, 2018, must be credentialed and participating (contracted) in the provider network of the Medicaid managed care entity to which the provider intends to submits claims for Medicaid services and to be eligible to receive Medicaid reimbursement, unless the provider agency is licensed and accredited, and has an executed single case agreement with the Medicaid managed care entity. executes a single case agreement with a licensed and accredited provider agency not in its network.~~

Staff

Effective on or after January 1, 2019, individuals rendering CPST services must have a minimum of a bachelor's degree from an accredited university or college ~~in the field of~~ with a major in counseling, social work, psychology or sociology. This can include credentialed peer support specialists as defined by LDH who meet all other the qualifications to provide the service. ~~Effective on or after January 1, 2019,~~ Individuals with a master's degree from an accredited university or college ~~in the field~~ of with a major in counseling, social work, psychology or sociology may render all aspects of CPST, including individual supportive behavioral interventions. Individuals providing CPST services for a licensed and accredited agency ~~Any individual~~ who do~~es~~ not possess the minimum master's degree in counseling, social work, psychology or sociology required to provide master's level CPST services, but who have a minimum of a bachelor's degree in counseling, social work, psychology or sociology, and who met all ~~provider~~ master's degree qualifications in effect prior to January 1, 2019, may continue to provide master's level CPST services for the same licensed and accredited provider agency. Prior to the individual rendering master's level CPST services for a different provider agency, the individual must ~~comply with the minimum master's degree provisions of this section~~ meet the minimum requirements in effect as of January 1, 2019.

NOTE – HUMAN SERVICES FIELD: It is LDH's position that master's degrees in Criminal Justice, Education, and Public Administration (among others) do not generally meet the requirements necessary to be considered human services related fields for purposes of providing master's level CPST services. Provider agencies employing individuals with master's degrees in academic majors other than counseling, social work, psychology or sociology for the provision of master's level CPST services must maintain documented evidence in

the individual's personnel file that supports the individual's academic program required at least 70% of its core curriculum be in the study of behavioral health or human behavior. Transcripts alone will not satisfy this requirement. A signed letter from the college or university stating the academic program required curriculum in which at least 70% of its required coursework was in the study of behavioral health or human behavior will satisfy the requirement. College or university published curriculum (may be published via college/university website) inclusive of required coursework demonstrating the program met the requirement is also acceptable.

NOTE – STAFF OF EVIDENCE BASED PROGRAMS: It is LDH's position that staff qualifications established by Act 582 of the 2018 Regular Legislative Session are not inclusive of LDH's recognized mental health rehabilitation evidence based programs (EBPs). LDH acknowledges the importance of staff qualifications aligning with EBP model requirements, recommendations and guidelines in order to adhere to the fidelity of these models. LDH recognizes the following programs as evidence based. Agencies providing these EBP services shall ensure their staff adhere to qualifications and requirements established by the EBP model: Assertive Community Treatment (ACT), Functional Family Therapy (FFT and FFT-CW), Homebuilders®, Multi-Systemic Therapy (MST) and Permanent Supportive Housing (PSH). For more information on PSH requirements, please refer to the Permanent Supportive Housing website under the LDH Office of Aging and Adult Services (OAAS).

- Services must be provided under regularly scheduled supervision of a licensed mental health professional (LMHP) or physician who is acting within the scope of his/her professional license and applicable state law. Effective on or after May 31, 2018, non-licensed individuals rendering CPST services are required to receive at least one hour per calendar month of personal supervision and training by the provider agency's mental health supervisor.

  NOTE: The term "supervision" refers to clinical support, guidance and consultation afforded to non-licensed staff, and should not be confused with professional board required clinical supervision of ~~bachelor's or master's level individuals or provisionally licensed~~ individuals pursuing licensure. Such individuals shall comply with current, applicable scope of practice and supervisory requirements identified by their respective licensing boards.

PSR Staff

- Prior to January 1, 2019, staff must have been at least eighteen (18) years old and have had a high school diploma or equivalent. Effective on or after January 1, 2019, staff rendering PSR services must have a minimum of a bachelor's degree from an accredited university or college with a major in counseling, social work, psychology or sociology. This can include credentialed peer support specialists as defined by LDH who meet all other qualifications to provide the service. Any individual rendering PSR services for a licensed and accredited agency who does not possess the minimum bachelor's degree required to provide PSR services, but who met the qualifications in effect prior to January 1, 2019, may continue to provide PSR services for the same provider agency. Prior to the individual rendering PSR services for a different provider agency, the individual must ~~comply with the minimum bachelor's degree provisions of this section~~ meet the new minimum requirements in effect.

CI/CS Staff

NOTE – HUMAN SERVICES FIELD: It is LDH's position that degrees in Criminal Justice, Education, and Public Administration (among others) do not generally meet the requirements necessary to be considered human services related fields for purposes of providing Crisis Intervention services. Provider agencies employing individuals with degrees in academic majors other than counseling, social work, psychology or sociology for the provision of Crisis Intervention services must maintain documented evidence in the individual's personnel file that supports the individual's academic program required at least 70% of its core curriculum be in the study of behavioral health or human behavior. Transcripts alone will not satisfy this requirement. A signed letter from the college or university stating the academic program required curriculum in which at least seventy percent (70%) of its required coursework was in the study of behavioral health or human behavior will satisfy the requirement. College or university published curriculum (may be published via college/university website) inclusive of required coursework demonstrating the program met the requirement is also acceptable.

January 2019

Revised section to clarify provider qualifications. Added details to provider qualifications for CPST and PSR due to legislation passed in 2018.
Publication date: 1/1/19

Community Psychiatric Support & Treatment
Provider Qualifications
Agency
To provide CPST services, agencies must meet the following requirements:

- Licensed – pursuant to La. R.S. 40:2151, et. seq.

- Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or The Joint Commission (TJC). Providers must report any denial, loss of, or any negative change in accreditation status, e.g. suspension, reduction in accreditation status, etc. ~~must be reported~~ in writing within 24 hours of receipt of ~~immediately upon~~ notification to the managed care entities with which the agency contracts or is being reimbursed.

  Prior to January 1, 2019, agencies must apply for accreditation and pay accreditation fees prior to being contracted with or reimbursed by a Medicaid managed care entity, and must maintain proof of accreditation application and fee payment. Agencies must attain full accreditation within 18 months of the initial accreditation application date.

  Effective January 1, 2019, provider agencies must be fully accredited or obtain a preliminary accreditation prior to contracting with a Medicaid managed care entity or rendering CPST services. Agencies must provide proof of full accreditation or preliminary accreditation to each managed care entity with which it is contracted. Agencies must maintain proof of continuous, uninterrupted full accreditation or preliminary accreditation at all times. Agencies providing CPST services must obtain a full accreditation status within 18 months of the agency's initial accreditation application date and shall provide proof of full accreditation once obtained to each managed care entity with which it is contracted.

  NOTE: Preliminary accreditation is defined as an accreditation status granted by an accrediting body to an unaccredited organization meeting certain organizational, administrative and service delivery standards prior to the organization attaining full accreditation status. Note that each national accrediting organization calls the initial, temporary accreditation by a different name, i.e. CARF (preliminary), COA (provisional), TJC (early survey).

- Prior to May 31, 2018, services must be provided under the supervision of a licensed mental health professional (LMHP) or physician who is acting within the scope of his/her professional license and applicable state law. Effective on or after May 31, 2018, agencies providing CPST services must employee at least one full-time physician or full-time LMHP to specifically serve as a full-time mental health supervisor to assist in the design and evaluation of treatment plans for CPST services. LMHPs serving in the role of mental health supervisor for this section are restricted to medical psychologist, licensed psychologist, licensed clinical social worker (LCSW), licensed professional counselor (LPC), licensed marriage and

family therapist (LMFT), or licensed Advanced Practice Registered Nurse (APRN) with a psychiatric specialization. For purposes of this section, the term "full-time" means employment by the provider agency for at least 35 hours per week.

- Effective January 1, 2019, has a National Provider Identification (NPI) number, and must include the agency NPI number and the NPI number of the individual rendering CPST services on its behalf on all claims for Medicaid reimbursement for dates of service on or after January 1, 2019.

- Effective May 31, 2018, must be credentialed and participating (contracted) in the provider network of the managed care entity to which the provider intends to submit claims for Medicaid services and reimbursement unless the managed care entity executes a single case agreement with a licensed and accredited provider agency not in its network.

Staff

To provide CPST services, staff must meet the following requirements:

- Prior to January 1, 2019, staff with a master's degree in social work, counseling, psychology or a related human services field may provide all aspects of CPST, including individual supportive behavioral interventions.

  Effective on or after January 1, 2019, individuals rendering CPST services must have a minimum of a bachelor's degree from an accredited university or college in the field of counseling, social work, psychology or sociology.

  Effective on or after January 1, 2019, individuals with a master's degree from an accredited university or college in the field of counseling, social work, psychology or sociology may render all aspects of CPST, including individual supportive behavioral interventions. Any individual who does not possess the minimal master's degree in counseling, social work, psychology or sociology required to provide master's level CPST services, but who met all provider qualifications in effect prior to January 1, 2019, may continue to provide master's level CPST services for the same provider agency. Prior to the individual rendering master's level CPST services for a different provider agency, the individual must comply with the minimum master's degree provisions of this section.

- Services must be provided under regularly scheduled supervision of a licensed mental health professional (LMHP) or physician who is acting within the scope of his/her professional license and applicable state law. Effective on or after May 31, 2018, non-licensed individuals rendering CPST services are required to receive at

least one hour per calendar month of personal supervision and training by the provider agency's mental health supervisor.

- Effective for dates of service rendered on or after January 1, 2019, individuals rendering CPST services for the licensed and accredited provider agency must have an NPI number and that NPI number must be included on any claim submitted by that provider agency for reimbursement.

Psychosocial Rehabilitation
Provider Qualifications
Agency
To provide psychosocial rehabilitation services, agencies must meet the following requirements:

- Licensed pursuant to La. R.S. 40:2151, et. seq.

- Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or The Joint Commission (TJC). Providers must report any denial, loss of, or any negative change in accreditation status, e.g. suspension, reduction in accreditation status, etc. ~~must be reported~~ in writing ~~immediately~~ within 24 hours of receipt of ~~upon~~ notification of such denial, loss of, or any negative change in accreditation status to the managed care entities with which the agency contracts or is being reimbursed.

Prior to January 1, 2019, agencies must apply for accreditation and pay accreditation fees prior to being contracted with or reimbursed by a Medicaid managed care entity, and must maintain proof of accreditation application and fee payment. Agencies must attain full accreditation within 18 months of the initial accreditation application date.

Effective January 1, 2019, provider agencies must be fully accredited or obtain a preliminary accreditation prior to contracting with a Medicaid managed care entity or rendering PSR services. Agencies must provide proof of full accreditation or preliminary accreditation to each managed care entity with which it is contracted. Agencies must maintain proof of continuous, uninterrupted full accreditation or preliminary accreditation at all times. Agencies providing PSR services must obtain a full accreditation status within 18 months of the agency's initial accreditation application date and shall provide proof of full accreditation once obtained to each managed care entity with which it is contracted.

NOTE: Preliminary accreditation is defined as an accreditation status granted by an accrediting body to an unaccredited organization meeting certain organizational, administrative and service delivery standards prior to the

organization attaining full accreditation status. Note that each national accrediting organization calls the initial, temporary accreditation by a different name, i.e. CARF (preliminary), COA (provisional), TJC (early survey).

- Prior to May 31, 2018, services must be provided under the supervision of a licensed mental health professional (LMHP) or physician who is acting within the scope of his/her professional license and applicable state law. Effective on or after May 31, 2018, agencies providing PSR services must employee at least one full-time physician or full-time LMHP to specifically serve as a full-time mental health supervisor to assist in the design and evaluation of treatment plans for PSR services. LMHPs serving in the role of mental health supervisor for this section are restricted to medical psychologist, licensed psychologist, licensed clinical social worker (LCSW), licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), or licensed Advanced Practice Registered Nurse (APRN) with a psychiatric specialization. For purposes of this section, the term "full-time" means employment by the provider agency for at least 35 hours per week.

- Effective January 1, 2019, has a National Provider Identification (NPI) number, and must include the agency NPI number and the NPI number of the individual rendering PSR services on its behalf on all claims for Medicaid reimbursement for dates of service on or after January 1, 2019.

- Effective May 31, 2018, must be credentialed and participating (contracted) in the provider network of the managed care entity to which the provider intends to submit claims for Medicaid services and reimbursement unless the managed care entity executes a single case agreement with a licensed and accredited provider agency not in its network.

Staff

To provide psychosocial rehabilitation services, staff must meet the following requirements:

- Prior to January 1, 2019, must be at least 18 years old and have a high school diploma or equivalent. Effective on or after January 1, 2019, must have a minimum of a bachelor's degree from an accredited university or college in the field of counseling, social work, psychology or sociology. Any individual who does not possess the minimal bachelor's degree required to provide PSR services, but who met all provider qualifications in effect prior to January 1, 2019, may continue to provide PSR services for the same provider agency. Prior to the individual rendering PSR services for a different provider agency, the individual must comply with the minimum bachelor's degree provisions of this section. Additionally, the

~~staff~~ individual must be at least three (3) years older than any individual they serve under the age of 18. This can include credentialed peer support specialists as defined by LDH.

- Effective for dates of service rendered on or after January 1, 2019, individuals rendering PSR services for the licensed and accredited provider agency must have an NPI number and that NPI number must be included on any claim submitted by that provider agency for reimbursement.

- Effective on or after May 31, 2018, non-licensed individuals rendering PSR services are required to receive at least one hour per calendar month of personal supervision and training by the provider agency's mental health supervisor.

June 2018

Updated to Provider Requirements and inserted language to include Behavioral Health Service Provider (BHSP) core services.
Publication date: 6/1/18
Effective in accordance with the licensing rule

Provider Responsibilities

- The provider must ensure no staff is providing unsupervised direct care prior to obtaining the results of the statewide criminal background check and addressing the results of the background check, if applicable.

Core Services

The Behavioral Health Service Provider (BHSP) must offer the following required core services to its clients. The BHSP shall provide these services through qualified staff and practitioners to its clients when needed and desired by its clients.

- Assessment;
- Orientation;
- Treatment;
- Client education;
- Consultation with professionals;
- Counseling services;
- Referral;
- Rehabilitation services;

- Crisis mitigation services; and
- Medication management.

Exception: BHSPs **exclusively** providing the evidence-based practice Functional Family Therapy (FFT/FFTCW), Homebuilders® or Multi-Systemic Therapy (MST) are excluded from the requirement to provide medication management. (See Appendices E-2 FFT/FFTCW, E-3 Homebuilders®, and E-4 MST for more information)

The BHSP Crisis Mitigation Plan

Crisis mitigation is defined as a BHSP's assistance to clients during a crisis that provides 24-hour on-call telephone assistance to prevent relapse or harm to self or others, to provide referral to other services, and to provide support during related crises. Referral to 911 or a hospital's emergency department alone does not constitute crisis mitigation services and does not satisfy this BHSP requirement.

The BHSP's crisis mitigation plan shall:

- Identify steps to take when a client suffers from a medical, psychiatric, medication or relapse crisis; and

- Specify names and telephone numbers of staff or contracted entities to assist clients in crisis.

If the BHSP contracts with another entity to provide crisis mitigation services, the BHSP shall have a written contract with the entity provided the crisis mitigation services.

The qualified individual, whether contracted or employed by the BHS provider, shall call the client within 30 minutes of receiving notice of the client's call.

Core Staffing

The BHSP shall abide by the following minimum core staffing requirements. BHSPs shall maintain a personnel file for each employee, contractor, and individual with whom they have an agreement to provide direct care services or to fulfill core and other staffing requirements. Documentation of employment, contracting or agreement must be in writing and executed via written signatures.

The minimum core staffing requirements are:

- Medical Director/Clinical Director;
- Administrator;
- Clinical Supervisor; and
- Nursing Staff.

Medical Director

A Medical Director who is a physician, or an advanced practice registered nurse, or a medical psychologist, with a current, unrestricted license to practice in the state of Louisiana with a minimum of two years of qualifying experience in treating psychiatric disorders.

Exception: BHSPs **exclusively** providing the evidence-based practice Functional Family Therapy (FFT/FFTCW), Homebuilders® or Multi-Systemic Therapy (MST) are excluded from the requirement of having a Medical Director. Such BHSPs shall have a Clinical Director in accordance with the Clinical Director description below.

The medical director has the following assigned responsibilities:

- Ensures that necessary medical services are provided the meet the needs of the clients;
- Provides oversight for provider policy/procedure, client treatment plans, and staff regarding the medical needs of the clients according to the current standards of medical practice;
- Directs the specific course of medical treatment for all clients;
- Reviews reports of all medically related accidents/incidents occurring on the premises and identifies hazards to the administrator;
- Participates in the development and implementation of policies and procedures for the delivery of services;
- Periodically reviews delivery of services to ensure care meets the current standards of practice; and
- Participates in the development of new programs and modifications.

In addition, the medical director has the following assigned responsibilities or designates the duties to a qualified practitioner:

- Writes the admission and discharge orders;

- Writes and approves all prescription medication orders;
- Develops, implements and provides education regarding the protocols for administering prescription and non-prescription medications on-site;
- Provides consultative and on-call coverage to ensure the health and safety of clients; and
- Collaborates with the client's primary care physician as needed for continuity of the client's care.

NOTE: The Medical Director may also fulfill the role of the Clinical Director, if the individual is qualified to perform the duties of both roles.

Clinical Director

A Clinical Director who, for those BHSPs, which **exclusively** provide the evidence-based practice Functional Family Therapy (FFT/FFTCW), Homebuilders® or Multi-Systemic Therapy (MST):

- Is a licensed psychiatrist, licensed psychologist, licensed clinical social worker (LCSW), licensed professional counselor (LPC), or licensed marriage and family therapist (LMFT) with a minimum of two years qualifying experience in treating psychiatric disorders and who maintains a current, unrestricted license to practice in the state of Louisiana;

- Has the following assigned responsibilities:
  - Ensures that the necessary services are provided to meet the needs of the clients,
  - Provides oversight for the provider policy/procedure, treatment planning, and staff regarding the clinical needs of the clients according to the current standards of clinical practice,
  - Directs the course of clinical treatment for all clients,
  - Reviews reports of all accidents/incidents occurring on the premises and identifies hazards to the Administrator,
  - Participates in the development and implementation of policies and procedures for the delivery of services,
  - Periodically reviews delivery of services to ensure care meets the current standards of practice, and
  - Participates in the development of new programs and modifications; and
  - Has the following responsibilities or designates the duties to a qualified practitioner:

- Provides consultative and on-call coverage to ensure the health and safety of clients, and
- Collaborates with the client's primary care physician and psychiatrist as needed for continuity of the client's care.

Administrator

An Administrator who:

- Has either a bachelor's degree from an accredited college or university or one year of qualifying experience that demonstrates knowledge, experience and expertise in business management;
- Is responsible for the on-site day to day operations of the BHSP and supervision of the overall BHSP's operation; and
- Shall not perform any programmatic duties and/or make clinical decisions unless licensed to do so.

Clinical Supervisor

A Clinical Supervisor who:

- Is a fully licensed LMHP that maintains a current and unrestricted license with its respective professional board or licensing authority in the state of Louisiana;
- Shall be on duty and on call as needed;
- Has a minimum of two years qualifying experience as an LMHP in the provision of services provided by the BHSP; and
- Has the following responsibilities:
    - Provides supervision utilizing evidence-based techniques related to the practice of behavioral health counseling;
    - Serves as resource person for other professionals counseling or providing direct services to clients with behavioral health disorders;
    - Attends and participates in treatment planning activities and discharge planning;
    - Functions as client advocate in treatment decisions;
    - Ensures BHSP adheres to rules and regulations regarding all behavioral health treatment, such as group size, caseload and referrals; and

- Assists the Medical Director with the development and implementation of policies and procedures.

Nursing Staff

Nursing Staff who:

- Provide nursing care and services under the direction of a registered nurse necessary to meet the needs of clients; and
- Have a valid current nursing license in the state of Louisiana; and
- Meet the medication needs of clients of the BHSP who are unable to self-administer medication, if needed.

NOTE: Nursing services may be provided directly by the BHSP via employed staff, or may be provided or arranged via written contract, agreement, policy, or other document. When not provided directly by the BHSP, the provider shall maintain written documentation of the arrangement.

Revisions made to clarify the medical necessity criteria and target population for mental health services; to add allowance for more frequent assessments and treatment plan updates based on individual needs; to add eligibility criteria for individuals 21 years of age and older; and to update language and revise service authorization requirements. Added details on assessment, treatment planning, eligibility criteria, and service utilization to align with Adult Mental Health Rule published 6/20/18.
Effective date: June 20, 2018

Assessment and Treatment Planning

- Assessments must be performed at least every ~~364~~365 days or as needed any time there is a significant change to the member's circumstances.

- Treatment plans shall be based on the assessed needs, ~~utilizing input from the member, family, natural supports, and treatment team~~ and developed by or in collaboration with an LMHP or physician in collaboration with direct care staff, the member, family and natural supports, and shall contain goals and interventions targeting areas of risk and need identified in the assessment. All team members, including the member and family, shall sign the treatment plan. The member shall receive a copy of the plan upon completion.

- The treatment plan shall be reviewed at least once every 365 days or when there is a significant change in the individual's circumstances.

Eligibility Criteria

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

An adult with a diagnosis of a substance use disorder or intellectual/developmental disability without an additional co-occurring qualifying mental health diagnosis shall not meet the criteria for adult mental health rehabilitation services.

Additional Adult Eligibility Criteria for Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR)

Members must meet the Substance Abuse and Mental Health Services Administration (SAMHSA) definition of, serious mental illness (SMI). In addition to having a diagnosable mental disorder, the condition must substantially interfere with, or limit, one or more major life activities, such as:

- Basic daily living (for example, eating or dressing);
- Instrumental living (for example, taking prescribed medications or getting around the community); and
- Participating in a family, school, or workplace.

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

Members receiving CPST and/or PSR must have at least a level of care of three on the LOCUS.

An adult with longstanding deficits who does not experience any acute changes in their status and has previously met the criteria stated above regarding LOCUS scores, but who now meets a level of care of two or lower on the LOCUS, and needs subsequent medically necessary services for stabilization and maintenance at a lower intensity, may continue to receive CPST services and/or PSR, if deemed medically necessary.

Service Utilization

Services are subject to prior authorization. Services may be provided at a facility, in the community, or in the individual's place of residence as outlined in the treatment plan. Services may be furnished in a nursing facility only in accordance with policies and procedures issued by the department.

May 2018

Revision made to add information concerning the use and completion process of the Member Choice Form.

Publication date: 5/3/18

Member Choice Form and Process

Members may only receive MHR services from one provider at a time with the following exceptions:

1. A member is receiving tenancy support through the Permanent Supportive Housing Program.
2. The behavioral health medical director for the member's health plan makes the determination that it is medically necessary and clinically appropriate to receive services from more than one MHR provider. The justification must be supported by the member's assessment and treatment plan. This decision must be reviewed at each reauthorization. If a member is receiving services from more than one MHR provider, the providers must have documented coordination of care.

All members must complete and sign a Member Choice Form prior to the start of MHR services and when transferring from one MHR provider to another. The Member Choice Form must be fully completed, signed by all parties, and received by the member's health plan prior to the start of services. The Member Choice Form is required to be part of the member's clinical record and subject to audit upon request. The health plan must monitor this process and ensure no overlapping authorizations, unless it is during a planned transition.

During a transfer, the initial provider should be given a service end date while the new provider must be given a start date by the member's health plan to ensure providers are reimbursed for services delivered. The health plan may allow a minimal amount of overlap between two providers to prevent a gap in services. In members' best interest during a transfer between two providers, it is expected that providers cooperate during the transition. The initial provider should share documentation and ensure a member has prescription refills if needed.

Providers must notify the member's health plan immediately if it is suspected that a member is receiving MHR services from more than one provider to prevent duplication of service providers.

Revision Details to Section 2.3 Outpatient Services - Outpatient Therapy by Licensed Practitioner of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

August 2021

Updated the provider qualifications.

Publication date: 8/23/21

Provider Qualifications

LPCs may render or offer prevention, assessment, diagnosis, and treatment, which includes psychotherapy of mental, emotional, behavioral, and addiction disorders to individuals, groups, organizations, or the general public by a licensed professional counselor, that is consistent with his/her professional training as prescribed by La. R.S. 37:1101 et seq. ~~However, LPCs may not assess, diagnose, or provide treatment to any individual suffering from a serious mental illness (SMI), when medication may be indicated, except when an LPC, in accordance with industry best practices, consults, and collaborates with a practitioner who holds a license or permit with the Louisiana State Board of Medical Examiners or a Louisiana licensed APRN, who is certified as a psychiatric nurse practitioner.~~ LPCs shall not engage in the practice of psychology or prescribe, either orally or in writing, distribute, dispense, or administer any medications. If intellectual, personality, developmental, or neuropsychological tests are deemed necessary, the licensed professional counselor shall make an appropriate referral. (Reference: Louisiana Mental Health Counselor Licensing Act; Section 1103).

LMFTs may render professional marriage and family therapy and psychotherapy services limited to prevention, assessment, diagnosis, and treatment of mental, emotional, behavioral, relational, and addiction disorders to individuals, couples and families, singly or in groups that is consistent with his/her professional training as prescribed by La. R.S. 37:1101 et seq. ~~However, LMFTs may not assess, diagnose, or provide treatment to any individual suffering from a serious mental illness (SMI), when medication may be indicated, except when an LMFT, in accordance with industry best practices, consults, and collaborates with a practitioner who holds a license or permit with the Louisiana State Board of Medical Examiners or a Louisiana licensed APRN, who is certified as a~~

~~psychiatric nurse practitioner. (Reference: Louisiana Mental Health Counselor Licensing Act; Section 1103.)~~ LMFTs shall not engage in the practice of psychology or prescribe, either orally or in writing, distribute, dispense, or administer any medications. If intellectual, personality, developmental, or neuropsychological tests are deemed necessary, the licensed marriage and family therapist shall make an appropriate referral. (Reference: Louisiana Mental Health Counselor Licensing Act; Section 1103). All treatment is restricted to marriage and family therapy issues.

LACs, who provide addiction services, must demonstrate competency, as defined by LDH, State law, Addictive Disorders Practice Act and regulations. LACs are not permitted to diagnose under their scope of practice under State law. LACs providing addiction and/or behavioral health services must adhere to their scope of practice license.

APRNs shall have a valid, current and unrestricted advanced practice registered nurse license, as a nurse practitioner or clinical nurse specialist, issued by the Louisiana State Board of Nursing. APRNs must be nurse practitioner specialists in adult psychiatric and mental health, and family psychiatric and mental health, or certified nurse specialists in psychosocial, gerontological psychiatric mental health, adult psychiatric and mental health and child-adolescent mental health and may practice to the extent that services are within the APRN's scope of practice.

Agency or Group Practice

- The provider must review the Department of Health and Human Services' Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) and the LDH State Adverse Actions website prior to hiring or contracting any employee or contractor that performs services that are compensated with Medicaid/Medicare funds, including but not limited to licensed and non-licensed staff, interns, and contractors. Once employed, the list must be checked once a month thereafter to determine if there is a finding that an employee or contractor has abused, neglected, or extorted any individual, or if they have been excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or by the Department of Health and Human Services' OIG.
- The provider is prohibited from knowingly employing, contracting with, or retaining the employment of or contract with, anyone who has a negative finding placed on the Louisiana State Adverse Action List, or who has been excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or by the Department of Health and Human Services OIG.
- Providers are required to maintain results in personnel records that these checks have been completed. The OIG maintains the LEIE on the OIG website at

https://exclusions.oig.hhs.gov), and the LDH Adverse Action website is located at https://adverseactions.ldh.la.gov/SelSearch;

Telehealth

Assessments, evaluations, individual psychotherapy, family psychotherapy, and medication management services may be reimbursed when provided via telecommunication technology. The LMHP is responsible for acting within the telehealth scope of practice as decided by their licensing board. The provider must bill the procedure code (CPT codes) with modifier "95", as well as Place of Service "02". Reimbursement will be at the same rate as a face-to-face service.

~~"Healthcare provider," as used herein, means a person, partnership, limited liability partnership, limited liability company, corporation, facility, or institution licensed or certified by this state to provide health care or professional services as a physician assistant, hospital, nursing home, . . . registered nurse, advanced practice registered nurse, licensed practical nurse, psychologist, medical psychologist, social worker, or licensed professional counselor. See La. R.S. 40:1223.3(3).~~

~~"Telehealth," as used herein, means a mode of delivering healthcare services that utilizes information and communication technologies to enable the diagnosis, consultation, treatment, education, care management, and self-management of patients at a distance from healthcare providers. See La. R.S. 40:1223.3(6). Additionally, "telehealth" means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between a provider and a patient. Telehealth allows services to be accessed when providers are in a distant site and patients are in the originating site. Telehealth facilitates patient self-management and caregiver support for patients.~~

January 2021

Updated the telehealth options.
Publication date: 1/5/21

Telehealth

Assessments, evaluations, individual psychotherapy, family psychotherapy, and medication management services may be reimbursed when provided via telecommunication technology.

August 2020

Updated the service list and telehealth options.
Publication date: 8/4/20

Licensed Practitioner Outpatient Therapy includes:

- ~~Individual~~ Outpatient psychotherapy (individual, family and group);
- ~~Family outpatient psychotherapy; Group outpatient psychotherapy;~~
- Psychotherapy for crisis;
- Psychoanalysis;
- Electroconvulsive therapy;
- Biofeedback;
- Hypnotherapy;
- ~~Mental health~~ Screening, assessment, examination, ~~Evaluation;~~ and ~~T~~testing;
- ~~• Psychosocial and~~ Diagnostic evaluation;
- Medication management; and
- ~~Medication administration; and Individual therapy with medical evaluation and management and case consultation~~
- Case conference* (CSoC only).

*Case Conferences are communications between Licensed Mental Health Professionals (LMHPs) or Psychiatrists for member consultation that is medically necessary for the medical management psychiatric conditions.

Provider Qualifications

Physician must be a~~,~~ psychiatrist or physician assistant ~~PA~~ working under protocol of a psychiatrist. ~~Registered nurse working within the scope of practice.~~

Telehealth

Individual psychotherapy, family psychotherapy, and medication management services may be

reimbursed when provided via telecommunication technology. The LMHP is responsible for acting within the telehealth scope of practice as decided by their licensing board. ~~Consultations, office visits, individual psychotherapy and pharmacological management services may be reimbursed when provided via telecommunication technology~~ The ~~consulting or expert~~ provider must bill the procedure code (CPT codes) with modifier "95", as well as Place of Service "02". Reimbursement will be at the same rate as a face-to-face service. ~~using the GT modifier and will be reimbursed at the same rate as a face-to-face service.~~

"Healthcare provider," as used herein," ~~-~~means a person, partnership, limited liability partnership, limited liability company, corporation, facility, or institution licensed or certified by this state to provide health care or professional services as a physician assistant, hospital, nursing home, . . . registered nurse, advanced practice registered nurse, licensed practical nurse, psychologist, medical psychologist, social worker, or licensed professional counselor. *See* La. R.S. 40:1223.3(3).

~~"~~Telehealth," as used herein, ~~-~~means a mode of delivering healthcare services that utilizes information and communication technologies to enable the diagnosis, consultation, treatment, education, care management, and self-management of patients at a distance from healthcare providers. *See* La. R.S. 40:1223.3(6). Additionally, "t ~~T~~elehealth" means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between a provider and a patient. Telehealth allows services to be accessed when providers are in a distant site and patients are in the originating site. Telehealth facilitates patient self-management and caregiver support for patients. ~~and includes synchronous interactions and asynchronous store and forward transfers.~~

November 2018

Revised section on telehealth to remove reference to billing for 'other licensed professional services' on page 7 of 8.
Publication date: 11/27/18

Telehealth
Consultations, office visits, individual psychotherapy and pharmacological management services may be reimbursed when provided via telecommunication technology. The consulting or expert provider must bill the procedure code (CPT codes) using the GT modifier and will be reimbursed at the same rate as a face-to-face service. ~~The originating site, with the consumer present, may bill as other licensed professional services.~~ "Healthcare provider" means a person, partnership, limited liability partnership, limited liability company, corporation, facility, or institution licensed or certified by this

state to provide health care or professional services as a physician assistant, hospital, nursing home, dentist, registered nurse, advanced practice registered nurse, licensed practical nurse, … psychologist, medical psychologist, social worker, licensed professional counselor…. "Telehealth" means a mode of delivering healthcare services that utilizes information and communication technologies to enable the diagnosis, consultation, treatment, education, care management, and self-management of patients at a distance from healthcare providers. Telehealth allows services to be accessed when providers are in a distant site and patients are in the originating site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

Revision Details to Section 2.3 Outpatient Services – Personal Care Services (PCS) of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

February 2022

New chapter added to the manual.
Publication date: 2/21/22

Revision Details to Section 2.3 Outpatient Services – Peer Support Services of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

August 2021

Changed staff title from Certified Peer Support Specialists (CPSS) with Recognized Peer Support Specialist (RPSS) and revised staff ratios.

Publication date: 8/26/21

Peer Support Services

The PSS are provided by ~~Certified~~ Office of Behavioral Health Recognized Peer Support Specialists (~~CPSS~~RPSS), who are individuals with personal lived experience with recovery from behavioral health conditions and successfully navigating the behavioral health services system.

Staff Ratios

- One (1) RPSS to twenty-five (~~20~~25) active members

RPSS Training

- ~~The CPSS must complete the OBH approved Peer Employment Training, which is a total of 76 hours of classwork, including a written midterm, written and practical final exam, with additional homework.~~ The RPSS employed by the provider agency must successfully complete a comprehensive peer training plan and curriculum that is inclusive of the Core Competencies for Peer Workers, as outlined by the Substance Abuse and Mental Health Services Administration (SAMHSA), and has been approved by the Office of Behavioral Health (OBH). Training must provide the RPSS with a basic set of competencies that complies with the Core Competencies of the profession to perform the peer support function. Successful completion requires obtaining the minimum qualifying score or better on required knowledge and skill assessments.

February 2021

New chapter added to the manual.

Publication date: 2/1/21

Revision Details to Section 2.4 Addiction Services of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

January 2020

Added language to the direct care staff requirements.
Publication date: 1/1/20

Provider Qualifications
Agency

- ~~Providers must review the Louisiana Nurse Aide Registry and the Louisiana Direct Service Worker Registry Louisiana Adverse Action website at: https://adversactions.dhh.la.gov/. against him/her;~~

- The provider must review the Louisiana State Adverse Action List prior to hiring any unlicensed direct care staff member. Once employed the registry must be checked at least every six months thereafter, or more often if there is a reason to suspect it is needed, to determine if there is a finding that a direct care staff has abused, neglected or extorted an individual being supported. The provider is prohibited from knowingly employing or contracting with, or retaining the employment of or contract with any unlicensed direct care staff who has had a finding placed on the Louisiana Adverse Action List (https://adverseactions.ldh.la.gov/SelSearch). Results are to be maintained in the individual's personnel record;

- ~~Non-licensed direct care staff have no record of negative findings on the Louisiana Nurse Aide Registry or the Louisiana Direct Service Worker Registry;~~ Direct care staff must not have a finding on the Louisiana Adverse Action List website at: https://adversactions.dhh.la.gov/. against him/her;

June 2019

Clarified language regarding ASAM Levels and Admission guidelines.
Publication date: 6/12/19

Admission guidelines (ASAM Level 2-WM)

ASAM level 2-WM services are available to recipients who meet the following criteria. The recipient exhibits:

- **Acute intoxication and/or withdrawal potential** – Experiencing moderate signs or symptoms of withdrawal, or there is evidence based on the history of substance use and previous withdrawal history, that withdrawal is imminent.
- **Biomedical conditions and complications** – None, or sufficiently stable to permit participation in ambulatory withdrawal management in an outpatient setting.
- **Emotional, behavioral or cognitive conditions and complications** – None to moderate. If present, complications can be safely addressed through monitoring, medication and treatment.
- **Readiness to change** – The patient has adequate understanding of ambulatory detoxification and expresses commitment to enter such a program. Member requires structured therapy and a programmatic milieu to promote treatment progress and recovery.
- **Relapse, continued use or continued problem potential** – Member is experiencing an intensification of symptoms related to substance use, which indicate a high likelihood of relapse or continue use or continue problems without close monitoring and support several times a week.
- **Recovery environment** – Sufficient supportive environment, however, member lacks the resources or skills necessary to maintain an adequate level of functioning without services in an ambulatory withdrawal management outpatient setting.

~~Facilities that provide ASAM level 2-WM ambulatory withdrawal management services with extended on-site monitoring provides care to patients whose withdrawal signs and symptoms are of moderate intensity but are sufficiently stable enough physically and mentally to permit participation in outpatient treatment. Medical and nursing services must be available on-site during hours of clinic operations and on-call after hours. The focus is on medical stabilization and preparation for transfer to a less intensive level of care.~~

Minimum Standards of Practice (ASAM Level 3.2-WM Adolescent)

- **Toxicology and drug screening**– Toxicology and drug screenings are medically monitored. A physician may waive drug screening if and when individual signs list of drugs being used and understands that his/her dishonesty could result in severe medical reactions during withdrawal management process.

November 2018

Revised core requirements, provider qualifications, and staffing requirements for the American Society of Addiction Medicine (ASAM) levels outlined in the document. Updated the Addiction chapter to align with the latest ASAM edition and the BHS licensing rule.
Publication date: 11/27/18

Additional Service Criteria
Providers must maintain medical records that include a copy of the assessment/evaluation, treatment plan, the name of the individual, dates of services provided, nature, content, and units of rehabilitation services provided and progress made toward functional improvement and goals in the treatment plan. (See 2.6 Record Keeping.)

~~These ASAM level services cannot be provided in an institute of mental disease (IMD).~~

ASAM levels of care ~~require~~ are subject to prior approval and reviews on an ongoing basis, as determined necessary by LDH to document compliance with the national standards.

Alcohol and Drug Assessment and Referrals ~~Programs~~
Alcohol and drug assessment and referrals ~~programs~~ provide ongoing assessment and referral services for individuals presenting a current or past use pattern of alcohol or other drug use. The assessment is designed to gather and analyze information regarding a member's biopsychosocial, substance use and treatment history ~~current substance use behavior and social, medical and treatment history~~. The purpose of the assessment is to provide sufficient information for problem identification and, if appropriate, substance use-related treatment or referral. A licensed provider shall comply with licensing standards and any further LDH standards outlined below in regard to assessment practices ~~must develop, implement and comply with policies and procedures that establish processes for referrals for a member~~. Once an individual receives an assessment, a staff member shall provide the individual with the identified clinical recommendation. Evaluations shall include the consideration of appropriate psychopharmacotherapy.
Effective date 4/1/19 - There shall be evidence that the member was assessed to determine if Medication Assisted Treatment (MAT) was a viable option of care, based on SUD diagnosis. ~~A licensed provider may conduct an initial screen of an individual's presenting substance use problem before conducting an assessment of the individual. A licensed provider must comply with licensing standards in regard to assessment practices. Once an individual receives an assessment, a staff member must provide the individual~~

~~with a recommendation for further assessment or treatment and an explanation of that recommendation.~~

Effective date 4/1/19 - SUD providers, when clinically appropriate, shall

- educate members on the proven effectiveness, benefits and risks of Food and Drug Administration approved MAT options for their SUD;
- provide onsite MAT or refer to MAT offsite; and
- document member education, access to MAT and member response in the progress - notes.

Effective date 4/1/19 - Residential SUD providers shall provide MAT onsite or facilitate access to MAT offsite which includes coordinating with the member's health plan for referring to available MAT provider and arranging Medicaid non-emergency medical transportation if other transportation is not available for the patient.

Core Requirements for the Screening, Assessment and Treatment Planning Process:
A triage screening is conducted to determine eligibility and appropriateness (proper member placement) for admission and referral. (The MCO/CSoC contractor ensures that pre-certification requirements are met.)

A comprehensive bio-psychosocial assessment and ASAM 6 Dimensional risk evaluation must be completed prior to admission, which substantiates member placement at the appropriate ASAM level of care. The evaluation must be reviewed and signed by an LMHP.

A physical examination or appropriate referral within 72 hours if indicated by the physician, nursing assessment or screening process.

A drug screening is conducted when the member's history is inconclusive or unreliable.

An appropriate assignment to level of care with referral to other appropriate services as indicated shall be made.

For residential facilities, diagnostic laboratory tests or appropriate referral shall be made as required to prevent spread of contagious/communicable disease, or as indicated by physical examination or nursing assessment.

Treatment plans shall be based on the evaluations to include person-centered goal and objectives. The treatment plan shall be developed within 72 hours within residential facilities with active participation of the individual, family and providers and be based on the individual's condition and the standards of practice for the provision of rehabilitative services. The treatment plan shall identify the medical or remedial services intended to reduce the identified condition, as well as the anticipated outcomes of the individual. The treatment plan shall include a referral to self-help groups such as AA, Al-Anon, and NA.

The treatment plan must specify the frequency, amount and duration of services. (See 2.6 Record Keeping.) The treatment plan must be signed by the LMHP or physician responsible for developing the plan. The plan will specify a timeline for re-evaluation of the plan that is, at least, an annual redetermination.

The re-evaluation shall involve the individual, family and providers and include a re-evaluation of plan to determine whether services have contributed to meeting the stated goals. A new treatment plan shall be developed if there is no measureable reduction of disability or restoration of functional level. The new plan shall identify different rehabilitation strategy with revised goals and services. If the services are being provided to a youth enrolled in a wrap-around agency (WAA), the substance use provider must either be on the Child Family Team (CFT) or will work closely with the CFT. Substance use service provision will be part of the youth's plan of care (POC) developed by the team.

Screening, Assessment and Treatment Plan Review (all ASAM Levels)
The treatment plan is reviewed/updated in collaboration with the member, as needed, or at minimum of every -- days or more frequently if indicated by the member's needs and documented accordingly

Staffing Requirements (all ASAM Levels)
- There is at least one LMHP or UP under the supervision of an LMHP on-site when clinical services are being provided;

ASAM Level 1 Outpatient Treatment
These programs offer comprehensive, coordinated and defined services that may vary in level of intensity but are fewer than nine contact hours per week for adults and fewer than six hours a week for adolescents. ~~or less per week~~.

ASAM Level 2.1 Intensive Outpatient Treatment
These programs offer comprehensive, coordinated and defined services that may vary in level of intensity but must be a minimum of nine contact hours per week for adults, ~~18 years of age and older,~~ ~~(~~and a minimum of six hours per week for adolescents, ~~0-17 years of age)~~ at a minimum of three days per week with a maximum of 19 hours per week.

Staffing Requirements (ASAM Level 2-WM)
- There is a clinical supervisor available on-site for supervision as needed and available on call at all times.

Admission Guidelines (ASAM Level 3.2-WM – Adolescent/Adult)
1. Acute intoxication and/or withdrawal potential – The member is experiencing signs and symptoms of withdrawal, or there is evidence that a withdrawal syndrome is imminent (based on history of substance use, age, gender, or

previous withdrawal). The patient is assessed as not requiring medications, but requires this level of service to complete detoxification.

2. Biomedical conditions and complications – None or mild.

3. Emotional, behavioral or cognitive conditions and complications – None to Mild severity; need structure to focus on recovery; if stable, a co-occurring disorder capable program is appropriate.

4. Readiness to change – The member has little awareness and needs intervention to engage and stay in treatment, or there is high severity in this dimension.

5. Relapse, continued use or continued problem potential – The member has little awareness and need intervention available to prevent continued use, with imminent dangerous consequences because of cognitive deficits.

6. Recovery environment – The member's recovery environment is not supportive of detoxification and entry into treatment, and the patient does not have sufficient coping skills to safely deal with the problems in their recovery environment or the patient recently has not demonstrated an inability to complete detoxification at a less intensive level of service, as by continued use.

Minimum Standards of Practice (ASAM Level 3.2-WM Adolescent/Adult)

• Toxicology and drug screening ~~– Toxicology and drug screening are not required in this level of care.~~

Admission Guidelines (ASAM Level 3.3 Adult)

3. Emotional, behavioral or cognitive conditions and complications – Mild to moderate severity; need structure to focus on recovery. Mental status is assessed as sufficiently stable to permit the member to participate in therapeutic interventions provided at this level of care. If stable, a co-occurring disorder capable program is appropriate. If not, a co-occurring disorder enhanced program is required. Treatment should be designed to respond to the member's cognitive deficits.

4. Readiness to change – Has little awareness of the need for continuing care or the existence of his/her substance use or mental health problem and need for treatment and thus has limited readiness to change. Despite experiencing serious consequences of effects of SUD the member has marked difficulty in understanding the relationship between his/her substance use, addiction, mental health or life problems and impaired coping skills and level of functioning. and needs intervention to engage and stay in treatment, or there is high severity in this dimension.

5. Relapse, continued use or continued problem potential – Has little awareness and needs intervention available to prevent continued use, he or she is in imminent danger of continued substance use or emotional health problems with dangerous emotional, behavioral or cognitive consequences. The member's cognitive impairment has limited his/her ability to identify and cope with relapse triggers and high-risk situations. He/she requires relapse prevention activities that are delivered at a slower pace, more concretely, and more repetitively in a setting that provides 24-hour structure and support to prevent imminent dangerous consequences with imminent dangerous consequences because of cognitive deficits.

Additional Provider Requirements for ASAM Level 3.3 - Women with Dependent Children Program

- Offer weekly parenting classes in which attendance is required;
- Provide access to ~~Offer~~ to family planning services;
- Staff members have at least eight hours of training in the following areas prior to supervising children:
  - Chemical dependency and its impact on the family;
  - Child development and age-appropriate activities;
  - Child health and safety;
  - Universal precautions;
  - Appropriate child supervision techniques; and
  - Signs of child abuse; or
  - A licensed day care provider pursuant to a written agreement with the provider.
- The provider shall maintain a staff-to-child ratio that does not exceed 1:3 for infants (18 months and younger) and 1:6 for toddlers and children.
- The provider shall address the specialized and therapeutic needs and care for the dependent children and develop an individualized plan of care to address those needs, to include goals, objectives and target dates; and provide age-appropriate education, counseling, and rehabilitation services for children; and
- The daily activity schedule for the children shall include a variety of structured and unstructured age appropriate activities.

Admission Guidelines (ASAM Level 3.5 Adolescent/Adult)

4. Readiness to change: Motivational interventions have not succeeded at a less intensive level of care. Has limited insight or awareness into the need for treatment. Has marked difficulty in understanding the relationship between his/her substance use, addiction, mental health, or life problems and his/her

impaired coping skills and level of functioning that may result in severe life consequences from continued use indicating a need for a 24-hour level of care. ~~Has marked difficulty with or opposition to treatment, with dangerous consequences, or there is high severity in this dimension but not in others. The member, therefore, needs ASAM Level 1 placement with inclusion of Motivational Enhancement Therapy (MET). MET is a therapeutic intervention and a component part of the program.~~

5. Relapse, continued use or continued problem potential: Has no recognition of the skills needed to prevent continued use, with imminently dangerous consequences to self or others. Demonstrates a history of repeated incarcerations with a pattern of relapse to substances and uninterrupted use outside of incarceration. Unable to control use of alcohol or other drugs and/or antisocial behaviors with risk of harm to self or others.
6. Recovery environment: Living and social environments has a high risk of neglect or abuse, ~~Environment is dangerous~~, and member lacks skills to cope outside of a highly structured 24-hour setting.

Admission Guidelines for ASAM Level 3.7 – Adult

2. Biomedical conditions and complications – Moderate to severe conditions (which require 24-hour nursing and medical monitoring or active treatment but not the full resources of an acute care hospital). Or the interaction of the patient's biomedical conditions and continued alcohol or drug use places the patient at significant risk of damage to physical health.

3. Emotional, behavioral or cognitive conditions and complications – Moderate to severe psychiatric conditions and complications or history of moderate to high psychiatric decompensation or moderate to high risk of harm to self, other, or property or is in imminent danger of relapse without 24 hour structure and support and medically monitored treatment, including stabilization with psychotropic medications. ~~Moderate to severe conditions and complications (such as diagnosable co-morbid psychiatric disorders or symptoms). These symptoms may not be severe enough to meet diagnostic criteria but interfere or distract from recovery efforts. Examples include:~~
   - ~~Anxiety/hypomanic or depression;~~
   - ~~Cognitive symptoms such as compulsive behaviors, suicidal or homicidal ideation with a recent history of attempts but no specific plan; and/or~~
   - ~~Hallucinations and delusions (without acute risk to self or others) are interfering with abstinence, recovery and stability to such a degree that the individual needs a structured 24-hour, medically monitored (but not medically managed) environment to address recovery efforts.~~

Admission Guidelines (ASAM Level 3.7 WM Adult)

1. Acute intoxication and/or withdrawal potential – Member is experiencing signs and symptoms of severe withdrawal, or there is evidence that a severe withdrawal

syndrome is imminent (based on history of substance use, age, gender, or previous withdrawal). There is a strong likelihood that the patient will require medications.

2. Biomedical conditions and complications – Mild to Moderate, but can be managed at level 3.7WM by medical monitoring. Treatment should be designed to respond to the member's medical needs associated with withdrawal management.

3. Emotional, behavioral or cognitive conditions and complications – Mild to moderate severity; need structure to manage comorbid physical, emotional, behavioral or cognitive conditions that can be managed in this setting but which increase the clinical severity of the withdrawal and complicates withdrawal management.

4. Readiness to change – Member has little awareness and needs intervention to engage and stay in treatment, or there is high severity in this dimension.

5. Relapse, continued use or continued problem potential – Member has little awareness and need intervention available to prevent continued use, with imminent dangerous consequences because of cognitive deficits.

6. Recovery environment – Member's recovery environment is not supportive of detoxification and entry into treatment and the patient does not have sufficient coping skills to safely deal with the problems in the recovery environment or the patient recently has demonstrated an inability to complete detoxification at a less intensive level of service, as by continued use.

Admission Guidelines (ASAM Level 4 WM)

Admission to Level 4WM requires meeting the criteria below in dimensions 1, 2, and/or 3. Problems may also exist from mild to severe in dimensions 4, 5, and/or 6, however they are secondary to dimensions 1, 2, and 3 for the 4WM level of care. If the only severity is in dimensions 4, 5, and/or 6 without high severity in 1, 2 and/or 3, then the member does not qualify for level 4WM.

1. Acute intoxication and/or withdrawal potential – Member is experiencing signs and symptoms of severe, unstable withdrawal, or there is evidence that a severe, unstable withdrawal syndrome is imminent (based on history of substance use, age, gender, or previous withdrawal). An acute care setting is required to manage the severity or instability of the withdrawal symptoms.
2. Biomedical conditions and complications –A significant acute biomedical condition that may pose a poses substantial risk of serious or life-threatening consequences during severe, unstable withdrawal or there is risk of imminent

withdrawal. The biomedical conditions and complications require 24 hour medical and nursing care and the full resources of an acute care hospital.

3. Emotional, behavioral or cognitive conditions and complications – A significant acute psychiatric or cognitive condition requires a 24 hour medical and nursing acute care setting to stabilize during severe, unstable withdrawal or there is evidence that a severe, unstable withdrawal syndrome is imminent (based on history of substance use, age, gender, or previous withdrawal).
4. Readiness to change – See admission guidelines above.
5. Relapse, continued use or continued problem potential – See admission guidelines above.
6. Recovery environment – See admission guidelines above.

~~**Limitations/Exclusions and Fee Schedules (ASAM Level 4 WM)**~~

~~As outlined in the Medicaid provider manuals and fee schedules, the MCO will pay the provider at the billed amount up to the fee schedule amount noted.~~

Revision Details to Section 2.4 Addiction Services – Opioid Treatment Programs (OTP) of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

December 2021

Added care coordination expectations.

Publication date: 12/21/21

Treatment Services

8. Care Coordination:

a. Services provided to members must include communication and coordination with the other health care providers as it relates to the member's OUD treatment. Coordination with other health care systems shall occur, as needed, to achieve the treatment goal.

January 2021

Added reimbursement methodology.

Publication date: 1/5/21

Physician Examination

A complete physical examination, including a drug screening test, by the OTP's physician must be conducted before admission to the OTP. A full medical exam, including results of serology and other tests, must be completed within 14 days of admission. The physician shall ensure members have a Substance Use or Opioid Use Disorder. The member must have been addicted to opiates ~~An OUD must be present~~ for at least one year before admission for treatment, or meet exception criteria, as set in federal regulations, as determined by a physician.

Reimbursement

Reimbursement for Methadone for OUD treatment will only be made to OTPs, which are federally approved by SAMHSA and the DEA, and regulated by LDH, which includes OBH and HSS. A provider subspecialty code 8V has been established for the OTPs/Methadone clinics as sole source providers.

The 8V subspecialty has two bundled rate options. H0020 will be used for a bundled rate reimbursement for Methadone treatment. H0047 will be used for a bundled rate for Buprenorphine treatment, but excludes the ingredient cost of the medication. Buprenorphine medication will be billed separately using the applicable J-codes (J0571-J0575) depending on dosage amounts.

Bundled rates for the OTPs will facilitate the practical needs of member-centered treatment in the administration of Medication Assisted Treatment (MAT) to integrate the provision of counseling and medical services. It strengthens recovery and decreases recidivism in members diagnosed within the substance use disorder spectrum.

The table below provides an explanation of available codes for the OTPs/Methadone clinics.

Code	*Explanation of Benefits*
H0020	**Methadone Bundled Rate** Bundled rate includes all state and federal regulatory mandated components of treatment. Services include but are not limited to the following: • Medication: This includes the administration, dosing, and dispensing of Methadone as per the member's treatment plan; • Counseling: Members are required to participate in group or individual sessions as part of the member's treatment plan; • Urine Drug Testing: This includes the urine drug testing or other laboratory tests deemed medically necessary; • Physical examinations by a physician or advanced practice registered nurse; • Evaluation and management visits; • Case management; and • Laboratory Services. The OTP may be reimbursed for the bundled rate for participants receiving take home doses in accordance with state and federal regulations and the member's treatment plan phase. Guest dosing occurs when a member receives Methadone dosing at another OTP other than their primary/home-based OTP clinic. The guest dosing provider will bill for the bundled rate and provide clinical care, if appropriate, that is coordinated with the "home" provider and Methadone Central Registry (MCR) to ensure correct dosing.

H0047	**Buprenorphine Bundled Rate** Bundled rate includes all components of treatment, except for the Buprenorphine medication. Services include but are not limited to the following: • Assessment and individualized treatment plan, • Individual and group counseling, • Urine Drug Testing or laboratory testing, and • Coordination of medically necessary services. Buprenorphine medication will be billed separately using the applicable J-codes (J0571-J0575) depending on dosage amounts.

October 2020

New chapter added to the manual.
Publication date: 10/7/20
Effective date: 1/20/20

Revision Details to Section 2.5 CSoC of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

May 2021

Clarified the training requirements for Short Term Respite providers.
Publication date: 5/27/21

Provider Qualifications
Staff

- Completion of The Family Involvement Center's Short Term Respite Provider training ~~according to the~~ curriculum approved by OBH prior to providing the service. (See Appendix D.)

January 2020

Added language to the direct care staff requirements for Parent Support and Training, Youth Support and Training, Independent Living/Skills Building and Short-Term Respite Care.
Publication date: 1/1/20

Provider Qualifications

- The provider must review the Department of Health and Human Services' Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) and the LDH State Adverse Actions website prior to hiring or contracting any employee or contractor that performs services that are compensated with Medicaid/Medicare funds, including but not limited to licensed and unlicensed staff, interns and contractors. Once employed, the lists must be checked once a month thereafter to determine if there is a finding that an employee or contractor has abused, neglected or extorted any individual or if they have been excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid

or the Department of Health and Human Services' Office of Inspector General. The provider is prohibited from knowingly employing or contracting with, or retaining the employment of or contract with, anyone who has a negative finding placed on the Louisiana State Adverse Action List, or who have been excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General.

Providers are required to maintain results in personnel records that checks have been completed. The OIG maintains the LEIE on the OIG website (https://exclusions.oig.hhs.gov) and the LDH Adverse Action website is located at https://adverseactions.ldh.la.gov/SelSearch;

Parent Support Specialist, Youth Support Specialist, Transition Coordinator, and staff of Short Term Respite

- Employees and contractors must not be excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General;

- Direct care staff must not have a finding on the Louisiana State Adverse Action List;

July 2018

Revised to remove the fingerprinting specifications on pages 4, 6, 10, and 12.
Publication date: 7/20/18
Effective date: October 6, 2017

April 2018

Revision was made to clarify that parent support and training, youth support and training, and independent living/skills building services are not to be provided in the provider's place of residence (pages 3, 9, and 14).
Publication date: 4/20/18
Effective date: 10/6/17

Please note: These activities may not be delivered in the provider's place of residence.

February 2018

Revisions made to add comprehensive peer training plan and curriculum requirement.

Publication date: 2/23/18

Effective date: 10/6/17

Each FSO is required to have and utilize a comprehensive peer training plan and curriculum, which is inclusive of the Peer Worker Core Competencies, as outlined by the Substance Abuse and Mental Health Services Administration (SAMHSA), and has been approved by the Office of Behavioral Health (OBH)-Coordinated System of Care (CSoC).

Revision Details to Section 2.6 Record Keeping of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

May 2020

Revisions made to incorporate technical edits and clarify documentation criteria for service progress notes.

Publication date: 5/29/20

Member Records

Providers must have a separate written record for each member served by the provider. For the purposes of continuity of care/support and for adequate monitoring of progress toward outcomes and services received, service providers must have adequate documentation of services offered and provided to members they serve. This documentation is an on-going chronology of activities undertaken on behalf of the member.

Providers shall maintain case records that include, at a minimum:

- Name of the individual;
- Dates and time of service;
- Assessments;
- Copy of the treatment plans, which include at a minimum:
- Goals and objectives, which are specific, measureable, action oriented, realistic and time-limited;
- Specific interventions;
- Service locations for each intervention;
- Staff providing the intervention;
- Estimated frequency and duration of service; and
- Signatures of the LMHP, member, and guardian (if applicable);
- Progress notes;
- Units of services provided;
- Crisis plan;
- Discharge plan; and
- Advanced directive.

A member can sign the assessment and treatment plans electronically. A member's electronic signature will be deemed valid under federal law if it is authorized by state law. Under the Louisiana Uniform Electronic Transactions Act, La. R.S. 9:2601 et seq. ("LUETA") an electronic signature is valid if: (1) signer intentionally, voluntary agrees to electronically sign the document; (2) the electronic signature is attributable to signer (i.e. be sure to have patient's printed name under signature); and (3) there are appropriate security measures in place which can authenticate the signature and prevent alteration of the signature (i.e. date and signature cannot be modified in the electronic health record).

Organization of Records, Record Entries and Corrections

Organization of individual member records and the location of documents within the record must be consistent among all records. Records must be appropriately thinned so that current material can be easily located in the record. All entries and forms completed by staff in member records must be legible, written in ink (not black) and include the following:

- The name of the person making the entry;
- The signature of the person making the entry;
- The functional title, applicable educational degree and/or professional license of the person making the entry;
- The full date of documentation; and
- Reviewed by the supervisor, if required.

Any error made by the staff in a member'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 member's records.

Service/Progress Notes

Service/progress notes document the service/progress billed. Service/progress notes must reflect the service delivered and are the "paper trail" for services delivered.

The following information is required to be entered in the service/progress notes to provide a clear audit trail and document claims:

- Name of member;
- Name of provider and employee providing the service(s);
- Service provider contact telephone number;

- Date of service contact;
- Start and stop time of service contact; and
- Content of each delivered service, including the reason for the contact describing the goals/objectives addressed during the service, specific intervention(s), progress made toward functional and clinical improvement.

~~Service/progress notes must be reviewed by the supervisor (if applicable) to ensure that all activities are appropriate in terms of the nature and time, and that documentation is sufficient.~~ A sample of the service/progress notes for each member seen by a non-LMHP must be reviewed by an LMHP supervisor at least monthly or more if needed. The signature of the LMHP attests to the date and time that the review occurred.

The service/progress note must clearly document that the services provided are related to the member's goals, objectives and interventions in the treatment plan, and are ~~deemed~~ medically necessary and clinically appropriate. Each service/progress note must document the specific interventions delivered including a description of what materials were used when teaching a skill. ~~and document the progress of the recipient with very specific information regarding response to the intervention and the plan for next time.~~ Service/progress notes should include each member's response to the intervention, noting if progress is or is not being made. Effective documentation includes observed behaviors if applicable and a plan for the next scheduled contact with the member. Each service/progress note must include sufficient detail to support the length of the contact. The content must be specific enough so a third party will understand the purpose of the contact and supports the service and claims data.

The only staff who may complete a service/progress note is the staff who delivered the service. It is not permissible for one staff to deliver the service and another staff to document and/or sign the service notes.

June 2018

Revisions have been made to add language to the 'Provider Responsibilities' section to ensure alignment with the adult mental health services requirements for maintaining case records. Added details on member record component and service note requirements to align with Adult Mental Health Rule published 6/20/18.
Publication date: 6/29/18

Member Records

Providers shall maintain case records that include, at a minimum:

- the name of the individual;
- the dates and time of service;
- assessments;
- a copy of the treatment plans, which include at a minimum:
    - goals and objectives, which are specific, measureable, action oriented, realistic and time-limited;
    - specific interventions;
    - the service locations for each intervention;
    - the staff providing the intervention; and
    - the dates of service;
- progress notes;
- crisis plan;
- discharge plan; and
- advanced directive.

Service/Progress Notes

- ~~Content of service contact.~~ Content of each delivered service, including the reason for the contact describing the goals/objectives addressed during the service, specific intervention(s), progress made toward functional and clinical improvement.

Revision Details to Appendix A Forms and Links of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

April 2021

Revisions made to Short Term Respite training curriculum.
Publication date: 4/xx/21

~~**Approved Short Term Respite (STR) Curriculum – Youth**~~
~~University of Idaho Respite Care Provider Training Manual~~
~~https://marketplace.uidaho.edu/C20272_ustores/web/product_detail.jsp?PRODUCTID=1636~~

September 2019

Formatting corrections and removed an inoperable link.
Publication date: 9/4/19

June 2018

Revised to include link to Chapter 1 - General Information and Administration of the Medicaid Services Manual. Added a link to as referenced in section 2.1.
Publication date: 6/29/18

Revision Details to Appendix D Approved Curriculum/ Equivalency Standards of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

February 2022

Updated training requirements for Adult Crisis Response providers.
Publication date: 2/24/22

Crisis Response Services (MCR, BHCC, CBCS) for Adults (Effective 3/1/2022 for MCR and CBCS and 4/1/22 for BHCC)

Approved Curriculum

The LSU Center for Evidence to Practice is the OBH-approved trainer for crisis providers. All required initial trainings and ongoing training/coaching are designed and delivered through the LSU Center for Evidence to Practice. All initial training must be completed prior to delivering services. The training includes the following:

- Topics of training may include but are not limited to the following:
  - Overview of Louisiana's Crisis System Continuum;
  - Crisis 101;
  - Person-Centered, Collaborative Engagements, Shared Decision Making & Voluntary Approach;
  - Stabilization, Regaining Cognitive Functioning and Resolution-Focused;
  - Trauma, Suicide, Mental Illness, Intellectual Disabilities and Substance Use Related to Crisis;
  - Verbal De-Escalation, Basics of Motivation, Empathic Response;
  - Assessment of Risk, Lethality Assessment/Scales;
  - Safety – Yours and Theirs (Safety Planning);
  - Peer Support in Crisis Response;
  - Self-Management Tools for Clients/Community/Consumers;
  - Voices of Those with Lived Experiences (Focus on Crisis);
  - Connecting to Resources/Supports [Urgent Care, Crisis Stabilization, and When Needed, Collaborating with 911, Emergency Departments – Louisiana Mental Health Laws, MCOs] Roles and Responsibilities/Follow-Up Practices;

- Self-Care, Self-Care Plans, and Sharing for Crisis Responders;
- Supervision (Who, What, When; Decision Making; Mandatory/Discretionary);
- Billing and Documentation of Services; and
- Continuous Quality Improvement Measures and Reporting.

- The following are in-person demonstration skills sessions:
  - Each one teach one (participants assigned to co-teach with trainer the highlights of online/earlier materials);
  - Active listening and empathy team competition;
  - Role plays, scene situations, demonstration (including culturally responsive care); and
  - Coaching sessions (sign-up and expectations).

May 2021

Updated training requirements for Short Term Respite providers.

Publication date: 5/27/21

Short Term Respite Care

Approved Curriculum

The Family Involvement Center's Short Term Respite Provider Training is the OBH-approved curriculum for Short Term Respite (STR) services. This training must be completed prior to delivering STR services. The training curriculum is designed to be delivered in a classroom setting by a trainer at the STR provider agency. The training consists of seven modules and typically takes approximately six hours to deliver, in addition to break time. The training modules include:

- Module 1: Respite Overview
- Module 2: Wraparound and the CFT Process
- Module 3: Family Culture and Values
- Module 4: Understanding Needs
- Module 5: Safety
- Module 6: Responding to Challenging Behaviors
- Module 7: Are you ready to be a Respite Provider?

The Office Behavioral Health approved Short Term Respite Training can be requested from Magellan of Louisiana at LACSOCPROVIDERQUESTIONS@magellanhealth.com. ~~University of Idaho Respite Care Provider Training Manual is the approved curriculum for Short Term Respite (STR) services. (See Appendix A for contact information.)~~

February 2021

Revisions made to add Peer Support Services training plan and curriculum requirement.
Publication date: 2/5/21

Peer Support Services
Approved Curriculum

The Certified Peer Support Specialist (CPSS) employed by the provider agency must successfully complete a comprehensive peer training plan and curriculum that is inclusive of the Core Competencies for Peer Workers, as outlined by the Substance Abuse and Mental Health Services Administration (SAMHSA), and has been approved by the Office of Behavioral Health (OBH). Training must provide the CPSS with a basic set of competencies that complies with the Core Competencies of the profession to perform the peer support function. Successful completion requires obtaining the minimum qualifying score or better on required knowledge and skill assessments.

The CPSS must complete a minimum of ten (10) Continuing Education Units (CEU) in the tenets of peer support approved by OBH per calendar year. Three (3) of the ten (10) CEUs must be in the area of Ethics. The other seven (7) will be in the principles and competencies related to tenets of peer support. Courses which are mandatory job trainings such as blood borne pathogens, sexual harassment, or prohibited political activity and are neither recovery oriented or related to Peer Support should not be counted towards this continuing education requirement. Documentation of completion of the ten approved CEUs shall be submitted to OBH by December 31 each year; otherwise, the CPSS will be considered to be lapsed. CEU courses may include:

- Wellness and Recovery;
- Cultural Competency;
- Person Centered Care;
- Mutuality;
- Advocacy;
- Communication;
- Conflict Resolution;
- Trauma Informed Care;
- Integrated Care;
- Partnering with Other Professionals;
- Wellness Recovery Action Plan (WRAP);
- Peer Support Whole Health;
- Intentional Peer Support;
- Mental Health First Aid;

- Suicide Prevention;
- Treatment/Discharge Planning;
- Health Insurance Portability and Accountability Act (HIPAA);
- Mandated Reporting;
- Target Health; and
- Chronic Conditions.

Psychosocial Rehabilitation - Adults
Approved Curriculum

The following training programs make up the approved curriculum for PSR services for adults:

- Boston Psychiatric Rehabilitation Model;
- Clubhouse Model; and
- ~~Social Skills Training Model.~~

Resource: Behavioral Health Service) Provider License
Information and regulations associated with the Behavioral Health Service (BHS) license rule may be found on the Louisiana Health Standards Section website available at the following link: https://ldh.la.gov/index.cfm/page/2990.
~~http://dhh.louisiana.gov/index.cfm/directory/detail/7950/catid/154~~.

February 2018

Revisions made to add comprehensive peer training plan and curriculum requirement.
Publication date: 2/23/18
Effective date: 10/6/17

Each FSO is required to have and utilize a comprehensive peer training plan and curriculum, which is inclusive of the Peer Worker Core Competencies, as outlined by the Substance Abuse and Mental Health Services Administration (SAMHSA), and has been approved by the Office of Behavioral Health (OBH)-Coordinated System of Care (CSoC).

Revision Details to Appendix E-1 Evidence Based Practices – Assertive Community Treatment (ACT) of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

September 2020

Revisions made to update service criteria for Assertive Community Treatment.
Publication date: 9/14/20

Assertive Community Treatment (ACT) services are community-based therapeutic interventions that address the functional problems of members who have the most complex and/or pervasive conditions associated with serious mental illness. These interventions are strength-based and focused on supporting recovery through the restoration of functional daily living skills, building strengths, increasing independence, developing social connections and leisure opportunities, and reducing the symptoms of their illness. Through these activities, the goal is to ~~symptom stability~~ increase the member's ability to cope and relate to others while enhancing the member's highest level of functioning in the community.

Interventions may address adaptive and recovery skill areas. These include, but are not limited to, supportive interventions to help maintain housing and employment ~~school and training opportunities~~, daily activities, health and safety, medication support, harm reduction, money management, entitlements, service planning, and coordination.

The primary goals of the ACT program and treatment regimen are:

- To lessen or eliminate the debilitating symptoms of mental illness or co-occurring addiction disorders the member experiences and to minimize or prevent recurrent acute episodes of the illness.

Target population

ACT serves members eighteen (18) years old or older who have a severe and persistent mental illness (SPMI) and members with co-occurring disorders listed in the diagnostic nomenclature (current diagnosis per DSM) that seriously impairs their functioning in the community.

Exception criteria:

- The member does not meet medical necessity criteria above, but is recommended as appropriate to receive ACT services by the ~~funding agency or designee~~ member's health plan, the ACT team leader, clinical director and psychiatrist, in order to protect public safety and promote recovery from acute symptoms related to mental illness. ~~Examples include those exiting institutions such as nursing facilities, prisons, and/or intermediate level inpatient psychiatric hospitals, or individuals with frequent incidence of emergency department (ED) presentations or involvement with crisis outreach.~~ Examples include:
    - Members discharging from institutions such as nursing facilities, prisons, and/or inpatient psychiatric hospitals,
    - Members with frequent incidence of emergency department (ED) presentations and/or involvement with crisis services,
    - Members identified as being part of the My Choice Louisiana Program target population who meet the following criteria, excluding those members with co-occurring SMI and dementia where dementia is the primary diagnosis:
        - Medicaid-eligible members over age eighteen (18) with SMI currently residing in NF or
        - Members over age eighteen (18) with SMI who are referred for a Pre-Admission Screening and Resident Review (PASRR) Level II evaluation of nursing facility placement on or after June 6, 2016

Assessment
A comprehensive person centered needs assessment must be completed within thirty (30) days of admission to the program. The assessment includes a complete history and ongoing assessment of:

- Psychiatric history, status and diagnosis,
- Level of Care Utilization System (LOCUS),
- Telesage Outcomes Measurement System, as appropriate,
- Psychiatric evaluation,
- Strengths assessment,
- Housing and living situation,
- Vocational, educational and social interests and capacities,
- Self-care abilities,
- Family and social relationships,
- Family education and support needs,
- Physical health,
- Alcohol and drug use,
- Legal situation, and
- Personal and environmental resources.

Services

Service provision for ACT will be based on the assessment and a recovery focused and strengths based treatment plan. The teams will provide the following supports and services to members:

- Crisis assessment and intervention;
- Symptom management;
- Individual counseling;
- Medication administration, monitoring, education and documentation;
- Skills restoration to enable self-care and daily life management, including utilization of public transportation, maintenance of living environment, money management, meal preparation, nutrition and health, locating and maintaining a home, skills in landlord/tenant negotiations and renter's rights and responsibilities.;
- Social and interpersonal skills rehabilitation necessary to participate in community based activities including but not limited to those necessary for functioning in a work, educational, leisure or other community environment;
- Peer support, supporting strategies for symptom/behavior management. This occurs through providing expertise about the recovery process, peer counseling to members with their families, as well as other rehabilitation and support functions as coordinated within the context of a comprehensive treatment plan.;
- Addiction treatment and education, including counseling, relapse prevention, harm reduction, anger and stress management;
- Referral and linkage or direct assistance to ensure that members obtain the basic necessities of daily life, including primary and specialty medical care, social and financial supports;

- Education, support and consultation to members' families and other major supports;
- Monitoring and follow-up to help determine if services are being delivered as set forth in the treatment plan and if the services are adequate to address the member's changing needs or status; ~~Monitoring and follow-up to help determine if psychiatric, substance use, mental health support and health related services are being delivered as set forth in the treatment plan, adequacy of services in the plan and changes, needs or status of member;~~
- Assist the member in applying for benefits. At a minimum, this includes Social Security Income, Medicaid and Patient Assistance Program enrollment; and
- For those members with forensic involvement, the team will liaise with the forensic coordinators as appropriate, further providing advocacy, education and linkage with the criminal justice system to ensure the member's needs are met in regards to their judicial involvement, and that they are compliant with the court orders.

Criteria for Discharge from Services

Members whose functioning has improved to the point that they no longer require the level of services and supports typically rendered by an Assertive Community Treatment team, should be transitioned into a lower level of care. When making this determination, considerations should be made regarding the member's ability to be served within the lower level of care available to them. The ACT team should begin implementing the discharge plan and preparing the member as functioning improves to the point that they no longer require the level of services and supports.

Program requirements

- Face-to-face encounter – ACT team must provide a minimum of six (6) clinically meaningful face to face encounters with the member monthly with the majority of encounters occurring outside of the office. Encounters should address components of the member's treatment plan, involve active engagement with the member, and actively assess their functioning. Teams must document clinically appropriate reasons if this minimum number of encounters cannot be made monthly. Teams must also document reasons contacts are occurring within the office. Efforts shall be made to ensure services are provided throughout the month. ~~At least 60 percent of all ACT team activities must be face-to-face, with approximately 90 percent of these encounters occurring outside of the office~~.

For those members transitioning from psychiatric or nursing facilities, ACT staff must provide a minimum of four encounters a week with the member during the first thirty (30) days post transition into the community. Encounters should be meaningful per the guidance

outlined above. If this minimum number of encounters cannot be made, ACT staff must document clinically appropriate reasons for why this number of encounters cannot be achieved. ~~ACT staff team must provide a minimum of six encounters with the service recipient or collateral contacts monthly and must document clinically appropriate reasons if this minimum number of encounters cannot be made monthly. At least 50 percent of the encounters shall be with the service recipient. Efforts shall be made to ensure services are provided throughout the month.~~

Provider Qualifications and Responsibilities

Each ACT team shall include at least:

- One (1) ACT team leader, who is a full time LMHP who must have both administrative and clinical skills;
- One (1) prescriber, who can be either a board-certified or board-eligible psychiatrist, a medical psychologist, or an advanced practice registered nurse (APRN) with specialty in adult mental health and meeting the medical director requirements of licensure for Behavioral Health Service (BHS) providers;
  In the event a medical psychologist or APRN are utilized, the team must be able to consult with psychiatrists.
- Two (2) nurses, at least one (1) of whom shall be a RN. Both nurses must have experience in carrying out medical functioning activities such as basic health and medical assessment, education and coordination of health care, psychiatric medical assessment and treatment, and administration of psychotropic medication;
- One other LMHP; (Effective March, 2021)
- One substance use specialist, who has a minimum of one (1) year specialized substance use training or supervised experience;
- One employment specialist, who has at least one (1) year of specialized training or supervised experience;
- One housing specialist, who has at least one (1) year of specialized training or supervised experience; and
- One peer specialist, who is self-identified as being in recovery from mental illness and/or substance use disorders who has successfully completed OBH required training and credentialing requirements as a peer specialist;

Staffing levels should increase proportional to the number of members served by the team in congruence with standards outlined within the DACTS.

Effective March, 2021, ACT teams must meet national fidelity standards as evidenced by the SAMHSA Assertive Community Treatment (ACT) Evidence-Based Practices (EBP) Toolkit.

- New teams:

- Must submit documentation to the MCO for contracting purposes including evidence of fidelity to the model including findings of self-evaluation using the DACTS/GOI.
    - The self-evaluation must reflect a minimum score of a 3.0 on the DACTS/GOI in order to be eligible to provide Medicaid funded services to members.
- Must undergo a fidelity review using the DACTS/GOI by an MCO-identified third party within six (6) months of implementation.
    - This review must reflect a minimum score of 3.0 on the DACTS/GOI in order to maintain certification and the ability to accept new members.
    - The team will implement an MCO approved corrective action plan immediately for any individual DACTS criterion that rates a one (1) or two (2). This plan should be implemented within thirty (30) days of findings or sooner as determined necessary by the MCO to mitigate health and safety issues for members.

- Existing teams:
    - Must participate in fidelity reviews using the DACTS/GOI conducted by the MCO or designee at least annually (every twelve (12) months) or more frequently as prescribed by the MCO.
        - The team will implement an MCO approved corrective action plan immediately for any individual DACTS criterion that rates a one (1) or two (2)
        - Must achieve a score 3.0 and above on the DACTS/GOI in order to maintain certification and the ability to accept new clients
        - If a 4.2 or higher on the DACTS/GOI is achieved, the team will be deemed as operating with "exceptional practice"
            - MCOs may grant extensions of eighteen (18) month intervals between fidelity reviews for teams operating with "exceptional practice".
    - Operating below acceptable fidelity thresholds:
        - Teams, which achieve less than a 3.0 on the DACTS/GOI, will forfeit the ability to accept new members though they can continue to work with existing members as long as there are no health and safety violations with operations as determined by the MCO or LDH.
            - Teams shall implement a remediation plan and undergo another fidelity review within three (3) months by the MCO or designee
                - If the team achieves more than a 3.0 on the DACTS/GOI in subsequent review, the team can begin accepting new referrals.

Additional Service Criteria

ACT agencies must adhere to requirements established in the Outpatient Services: Rehabilitation Services chapter of this manual. Please refer to that section for specific information on provider responsibilities.

Billing

~~Only direct staff face-to-face time with the member or family may be billed. ACT may be billed for under CPST but must be consistent with the CPST State Plan definition. CPST is a face-to-face intervention with the individual present; however, family or other collaterals may also be involved. Medicaid also does not pay when the vocational supports provided via ACT qualify for vocational rehabilitation funding, even if the vocational rehabilitation services are not available.~~

NOTE: Individualized substance use treatment will be provided to those members for whom this is appropriate; co-occurring disorder treatment groups will also be provided off-site of the ACT administrative offices, though they do not take the place of individualized treatment. ~~Substance use/mental health treatment will also include dialectical behavioral therapy, cognitive behavioral therapy (CBT) and motivational enhancement therapy~~.

The following activities may not be billed or considered the activity for which the ACT per diem is billed:

- Time spent doing, attending, or participating in recreational activities.
- Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide or an academic tutor.
- Habilitative services for the adult to acquire, retain, and improve the self-help, socialization and adaptive skills necessary to reside successfully in community settings.
- Child care services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
- Respite care.
- Transportation for the individual or family. Services provided in the car are considered transportation.
- Services provided under age 18.
- Covered services that have not been rendered.
- Services provided before approved authorization.
- Services rendered that are not in accordance with an approved authorization.
- Services not identified on the authorized treatment plan.

- Services provided without prior authorization.
- Services provided to the children, spouse, parents, or siblings of the eligible adult under treatment or others in the eligible member's life to address problems not directly related to the eligible member's issues and not listed on the eligible member's treatment plan.
- Services provided that are not within the provider's scope of practice.
- Any art, movement, dance or drama therapies.

- Anything not included in the approved ACT services description.

June 2019

Clarified language regarding Target Populations and Program Requirements.
Publication date: 6/12/19

Target population

Exception criteria:

- The individual does not meet medical necessity criteria above ~~I or II~~, but is recommended as appropriate to receive ACT services by the funding agency or designee, the ACT team leader, clinical director and psychiatrist, in order to protect public safety and promote recovery from acute symptoms related to mental illness. Examples include those exiting institutions such as nursing facilities, prisons, and/or intermediate level inpatient psychiatric hospitals, or individuals with frequent incidence of emergency department (ED) presentations or involvement with crisis outreach.

Program requirements

- ACT team must conduct ongoing monitoring and evaluation of program implementation through the collection of process and outcome measures. Process measures should be obtained through utilization of the EBP Fidelity Scale and General Organizational Index as found within the SAMHSA ACT Toolkit. Outcome measures such as homelessness, hospitalizations (psychiatric/medical), emergency department presentations (psychiatric/medical), incarcerations or arrests/detainments, substance use treatment (residential/inpatient), utilizations of primary care physician (PCP), employment and educational status should be collected in addition to the EBP fidelity measures.

Billing

~~Intensive case management (ICM) may be billed using a combination of codes licensed practitioner, PSR and CPST, subject to prior authorization. ICM is not an EBP and use of research based and evidence based practices is preferred over the use of ICM.~~

June 2018
Revised to update provider qualifications and responsibilities to ensure compliance with current licensing requirements.
Publication date: 6/1/18
Effective in accordance with the licensing rule

Provider Qualifications and Responsibilities

The MCO may contract with ACT teams meeting national fidelity standards as evidenced by the SAMHSA Assertive Community Treatment (ACT) Evidence-Based Practices (EBP) Toolkit.

ACT agencies must be licensed ~~in accordance with~~ pursuant to La. R.S. 40:2151, et. seq. for behavioral health service providers and accredited by an LDH approved national accrediting body: Commission on Accreditation of Rehabilitation Facilities (CARF), Council on Accreditation (COA) or The Joint Commission (TJC). Denial, loss of, or any negative change in accreditation status must be reported in writing immediately upon notification by the accrediting body of such denial, loss of, or any negative change in accreditation status to ~~their contracted MCOs in writing immediately upon notification by the accreditation body~~ the managed care entities with which the ACT agency contracts or is reimbursed.

NOTE: Effective March 14, 2017, ACT agencies must apply for accreditation and pay accreditation fees prior to being contracted with or reimbursed by a Medicaid managed care entity, and must maintain proof of accreditation application and fee payment. ACT agencies must attain full accreditation within 18 months of the initial accreditation application date. ACT Agencies contracted with a managed care entity prior to March 14, 2017, must attain full accreditation by September 14, 2018, i.e. 18 months from the initial effective date of the requirement for ACT agencies.

The provider agency must meet all qualifications as required for other outpatient and rehabilitation agencies and must maintain documentation and verification of licensure, accreditation, staff criminal background checks, TB testing, drug testing, evidence of fidelity to the model (via SAMHSA ACT EBP Toolkit) and required training for staff employed or contracted with the agency.

ACT agencies must adhere to all requirements established in the Provider Responsibilities section located in the Outpatient Services: Rehabilitation Services chapter of this manual. Please refer to that section for specific information on all provider responsibilities.

Revision Details to Appendix E-1 Evidence Based Practices – Assertive Community Treatment (ACT) of the Behavioral Health Services Provider Manual

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Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

September 2020

Revisions made to update service criteria for Assertive Community Treatment.
Publication date: 9/14/20

Assertive Community Treatment (ACT) services are community-based therapeutic interventions that address the functional problems of members who have the most complex and/or pervasive conditions associated with serious mental illness. These interventions are strength-based and focused on supporting recovery through the restoration of functional daily living skills, building strengths, increasing independence, developing social connections and leisure opportunities, and reducing the symptoms of their illness. Through these activities, the goal is to ~~symptom stability~~ increase the member's ability to cope and relate to others while enhancing the member's highest level of functioning in the community.

Interventions may address adaptive and recovery skill areas. These include, but are not limited to, supportive interventions to help maintain housing and employment ~~school and training opportunities~~, daily activities, health and safety, medication support, harm reduction, money management, entitlements, service planning, and coordination.

The primary goals of the ACT program and treatment regimen are:

- To lessen or eliminate the debilitating symptoms of mental illness or co-occurring addiction disorders the member experiences and to minimize or prevent recurrent acute episodes of the illness.

Target population

ACT serves members eighteen (18) years old or older who have a severe and persistent mental illness (SPMI) and members with co-occurring disorders listed in the diagnostic nomenclature (current diagnosis per DSM) that seriously impairs their functioning in the community.

Exception criteria:

- The member does not meet medical necessity criteria above, but is recommended as appropriate to receive ACT services by the ~~funding agency or designee~~ member's health plan, the ACT team leader, clinical director and psychiatrist, in order to protect public safety and promote recovery from acute symptoms related to mental illness. ~~Examples include those exiting institutions such as nursing facilities, prisons, and/or intermediate level inpatient psychiatric hospitals, or individuals with frequent incidence of emergency department (ED) presentations or involvement with crisis outreach.~~ Examples include:
    - Members discharging from institutions such as nursing facilities, prisons, and/or inpatient psychiatric hospitals,
    - Members with frequent incidence of emergency department (ED) presentations and/or involvement with crisis services,
    - Members identified as being part of the My Choice Louisiana Program target population who meet the following criteria, excluding those members with co-occurring SMI and dementia where dementia is the primary diagnosis:
        - Medicaid-eligible members over age eighteen (18) with SMI currently residing in NF or
        - Members over age eighteen (18) with SMI who are referred for a Pre-Admission Screening and Resident Review (PASRR) Level II evaluation of nursing facility placement on or after June 6, 2016

Assessment
A comprehensive person centered needs assessment must be completed within thirty (30) days of admission to the program. The assessment includes a complete history and ongoing assessment of:

- Psychiatric history, status and diagnosis,
- Level of Care Utilization System (LOCUS),

- Telesage Outcomes Measurement System, as appropriate,
- Psychiatric evaluation,
- Strengths assessment,
- Housing and living situation,
- Vocational, educational and social interests and capacities,
- Self-care abilities,
- Family and social relationships,
- Family education and support needs,
- Physical health,
- Alcohol and drug use,
- Legal situation, and
- Personal and environmental resources.

Services

Service provision for ACT will be based on the assessment and a recovery focused and strengths based treatment plan. The teams will provide the following supports and services to members:

- Crisis assessment and intervention;
- Symptom management;
- Individual counseling;
- Medication administration, monitoring, education and documentation;
- Skills restoration to enable self-care and daily life management, including utilization of public transportation, maintenance of living environment, money management, meal preparation, nutrition and health, locating and maintaining a home, skills in landlord/tenant negotiations and renter's rights and responsibilities.;
- Social and interpersonal skills rehabilitation necessary to participate in community based activities including but not limited to those necessary for functioning in a work, educational, leisure or other community environment;
- Peer support, supporting strategies for symptom/behavior management. This occurs through providing expertise about the recovery process, peer counseling to members with their families, as well as other rehabilitation and support functions as coordinated within the context of a comprehensive treatment plan.;
- Addiction treatment and education, including counseling, relapse prevention, harm reduction, anger and stress management;
- Referral and linkage or direct assistance to ensure that members obtain the basic necessities of daily life, including primary and specialty medical care, social and financial supports;
- Education, support and consultation to members' families and other major supports;
- Monitoring and follow-up to help determine if services are being delivered as set forth in the treatment plan and if the services are adequate to address the member's

changing needs or status; ~~Monitoring and follow-up to help determine if psychiatric, substance use, mental health support and health related services are being delivered as set forth in the treatment plan, adequacy of services in the plan and changes, needs or status of member;~~

- Assist the member in applying for benefits. At a minimum, this includes Social Security Income, Medicaid and Patient Assistance Program enrollment; and
- For those members with forensic involvement, the team will liaise with the forensic coordinators as appropriate, further providing advocacy, education and linkage with the criminal justice system to ensure the member's needs are met in regards to their judicial involvement, and that they are compliant with the court orders.

Criteria for Discharge from Services

Members whose functioning has improved to the point that they no longer require the level of services and supports typically rendered by an Assertive Community Treatment team, should be transitioned into a lower level of care. When making this determination, considerations should be made regarding the member's ability to be served within the lower level of care available to them. The ACT team should begin implementing the discharge plan and preparing the member as functioning improves to the point that they no longer require the level of services and supports.

Program requirements

- Face-to-face encounter – ACT team must provide a minimum of six (6) clinically meaningful face to face encounters with the member monthly with the majority of encounters occurring outside of the office. Encounters should address components of the member's treatment plan, involve active engagement with the member, and actively assess their functioning. Teams must document clinically appropriate reasons if this minimum number of encounters cannot be made monthly. Teams must also document reasons contacts are occurring within the office. Efforts shall be made to ensure services are provided throughout the month. ~~At least 60 percent of all ACT team activities must be face-to-face, with approximately 90 percent of these encounters occurring outside of the office~~.

For those members transitioning from psychiatric or nursing facilities, ACT staff must provide a minimum of four encounters a week with the member during the first thirty (30) days post transition into the community. Encounters should be meaningful per the guidance outlined above. If this minimum number of encounters cannot be made, ACT staff must document clinically appropriate reasons for why this number of encounters cannot be achieved. ~~ACT staff team must provide a minimum of six encounters with the service recipient or collateral contacts monthly and must document clinically appropriate reasons if this minimum number of encounters cannot be made monthly. At least 50 percent of the~~

~~encounters shall be with the service recipient. Efforts shall be made to ensure services are provided throughout the month.~~

Provider Qualifications and Responsibilities

Each ACT team shall include at least:

- One (1) ACT team leader, who is a full time LMHP who must have both administrative and clinical skills;
- One (1) prescriber, who can be either a board-certified or board-eligible psychiatrist, a medical psychologist, or an advanced practice registered nurse (APRN) with specialty in adult mental health and meeting the medical director requirements of licensure for Behavioral Health Service (BHS) providers;
  In the event a medical psychologist or APRN are utilized, the team must be able to consult with psychiatrists.
- Two (2) nurses, at least one (1) of whom shall be a RN. Both nurses must have experience in carrying out medical functioning activities such as basic health and medical assessment, education and coordination of health care, psychiatric medical assessment and treatment, and administration of psychotropic medication;
- One other LMHP; (Effective March, 2021)
- One substance use specialist, who has a minimum of one (1) year specialized substance use training or supervised experience;
- One employment specialist, who has at least one (1) year of specialized training or supervised experience;
- One housing specialist, who has at least one (1) year of specialized training or supervised experience; and
- One peer specialist, who is self-identified as being in recovery from mental illness and/or substance use disorders who has successfully completed OBH required training and credentialing requirements as a peer specialist;

Staffing levels should increase proportional to the number of members served by the team in congruence with standards outlined within the DACTS.

Effective March, 2021, ACT teams must meet national fidelity standards as evidenced by the SAMHSA Assertive Community Treatment (ACT) Evidence-Based Practices (EBP) Toolkit.

- New teams:
  - Must submit documentation to the MCO for contracting purposes including evidence of fidelity to the model including findings of self-evaluation using the DACTS/GOI.
    - The self-evaluation must reflect a minimum score of a 3.0 on the DACTS/GOI in order to be eligible to provide Medicaid funded services to members.

- Must undergo a fidelity review using the DACTS/GOI by an MCO-identified third party within six (6) months of implementation.
  - This review must reflect a minimum score of 3.0 on the DACTS/GOI in order to maintain certification and the ability to accept new members.
  - The team will implement an MCO approved corrective action plan immediately for any individual DACTS criterion that rates a one (1) or two (2). This plan should be implemented within thirty (30) days of findings or sooner as determined necessary by the MCO to mitigate health and safety issues for members.

- Existing teams:
  - Must participate in fidelity reviews using the DACTS/GOI conducted by the MCO or designee at least annually (every twelve (12) months) or more frequently as prescribed by the MCO.
    - The team will implement an MCO approved corrective action plan immediately for any individual DACTS criterion that rates a one (1) or two (2)
    - Must achieve a score 3.0 and above on the DACTS/GOI in order to maintain certification and the ability to accept new clients
    - If a 4.2 or higher on the DACTS/GOI is achieved, the team will be deemed as operating with "exceptional practice"
      - MCOs may grant extensions of eighteen (18) month intervals between fidelity reviews for teams operating with "exceptional practice".
  - Operating below acceptable fidelity thresholds:
    - Teams, which achieve less than a 3.0 on the DACTS/GOI, will forfeit the ability to accept new members though they can continue to work with existing members as long as there are no health and safety violations with operations as determined by the MCO or LDH.
      - Teams shall implement a remediation plan and undergo another fidelity review within three (3) months by the MCO or designee
        - If the team achieves more than a 3.0 on the DACTS/GOI in subsequent review, the team can begin accepting new referrals.

Additional Service Criteria

ACT agencies must adhere to requirements established in the Outpatient Services: Rehabilitation Services chapter of this manual. Please refer to that section for specific information on provider responsibilities.

Billing

~~Only direct staff face-to-face time with the member or family may be billed. ACT may be billed for under CPST but must be consistent with the CPST State Plan definition. CPST is a face-to-face intervention with the individual present; however, family or other collaterals may also be involved. Medicaid also does not pay when the vocational supports provided via ACT qualify for vocational rehabilitation funding, even if the vocational rehabilitation services are not available.~~

NOTE: Individualized substance use treatment will be provided to those members for whom this is appropriate; co-occurring disorder treatment groups will also be provided off-site of the ACT administrative offices, though they do not take the place of individualized treatment. ~~Substance use/mental health treatment will also include dialectical behavioral therapy, cognitive behavioral therapy (CBT) and motivational enhancement therapy~~.

The following activities may not be billed or considered the activity for which the ACT per diem is billed:

- Time spent doing, attending, or participating in recreational activities.
- Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide or an academic tutor.
- Habilitative services for the adult to acquire, retain, and improve the self-help, socialization and adaptive skills necessary to reside successfully in community settings.
- Child care services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
- Respite care.
- Transportation for the individual or family. Services provided in the car are considered transportation.
- Services provided under age 18.
- Covered services that have not been rendered.
- Services provided before approved authorization.
- Services rendered that are not in accordance with an approved authorization.
- Services not identified on the authorized treatment plan.
- Services provided without prior authorization.
- Services provided to the children, spouse, parents, or siblings of the eligible adult under treatment or others in the eligible member's life to address problems not directly related to the eligible member's issues and not listed on the eligible member's treatment plan.
- Services provided that are not within the provider's scope of practice.
- Any art, movement, dance or drama therapies.

- Anything not included in the approved ACT services description.

June 2019

Clarified language regarding Target Populations and Program Requirements.
Publication date: 6/12/19

Target population

Exception criteria:

- The individual does not meet medical necessity criteria above ~~I or II~~, but is recommended as appropriate to receive ACT services by the funding agency or designee, the ACT team leader, clinical director and psychiatrist, in order to protect public safety and promote recovery from acute symptoms related to mental illness. Examples include those exiting institutions such as nursing facilities, prisons, and/or intermediate level inpatient psychiatric hospitals, or individuals with frequent incidence of emergency department (ED) presentations or involvement with crisis outreach.

Program requirements

- ACT team must conduct ongoing monitoring and evaluation of program implementation through the collection of process and outcome measures. Process measures should be obtained through utilization of the EBP Fidelity Scale and General Organizational Index as found within the SAMHSA ACT Toolkit. Outcome measures such as homelessness, hospitalizations (psychiatric/medical), emergency department presentations (psychiatric/medical), incarcerations or arrests/detainments, substance use treatment (residential/inpatient), utilizations of primary care physician (PCP), employment and educational status should be collected in addition to the EBP fidelity measures.

Billing

~~Intensive case management (ICM) may be billed using a combination of codes licensed practitioner, PSR and CPST, subject to prior authorization. ICM is not an EBP and use of research based and evidence based practices is preferred over the use of ICM.~~

June 2018

Revised to update provider qualifications and responsibilities to ensure compliance with current licensing requirements.
Publication date: 6/1/18
Effective in accordance with the licensing rule

Provider Qualifications and Responsibilities

The MCO may contract with ACT teams meeting national fidelity standards as evidenced by the SAMHSA Assertive Community Treatment (ACT) Evidence-Based Practices (EBP) Toolkit.

ACT agencies must be licensed ~~in accordance with~~ pursuant to La. R.S. 40:2151, et. seq. for behavioral health service providers and accredited by an LDH approved national accrediting body: Commission on Accreditation of Rehabilitation Facilities (CARF), Council on Accreditation (COA) or The Joint Commission (TJC). Denial, loss of, or any negative change in accreditation status must be reported in writing immediately upon notification by the accrediting body of such denial, loss of, or any negative change in accreditation status to ~~their contracted MCOs in writing immediately upon notification by the accreditation body~~ the managed care entities with which the ACT agency contracts or is reimbursed.

NOTE: Effective March 14, 2017, ACT agencies must apply for accreditation and pay accreditation fees prior to being contracted with or reimbursed by a Medicaid managed care entity, and must maintain proof of accreditation application and fee payment. ACT agencies must attain full accreditation within 18 months of the initial accreditation application date. ACT Agencies contracted with a managed care entity prior to March 14, 2017, must attain full accreditation by September 14, 2018, i.e. 18 months from the initial effective date of the requirement for ACT agencies.

The provider agency must meet all qualifications as required for other outpatient and rehabilitation agencies and must maintain documentation and verification of licensure, accreditation, staff criminal background checks, TB testing, drug testing, evidence of fidelity to the model (via SAMHSA ACT EBP Toolkit) and required training for staff employed or contracted with the agency.

ACT agencies must adhere to all requirements established in the Provider Responsibilities section located in the Outpatient Services: Rehabilitation Services chapter of this manual. Please refer to that section for specific information on all provider responsibilities.

Revision Details to Appendix E-2 Evidence Based Practices Functional Family Therapy/Functional Family Therapy – Child Welfare (FFT/FFT-CW) of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

June 2018
Revised to update provider qualifications and responsibilities to ensure compliance with current licensing requirements.
Publication date: 6/1/18
Effective in accordance with the licensing rule

Provider Qualifications and Responsibilities
FFT/FFT-CW agencies must adhere to all requirements established in the Provider Responsibilities section located in the Outpatient Services: Rehabilitation Services chapter of this manual.

EXCEPTIONS:

1. BHSPs ***exclusively*** providing the evidence-based practice Functional Family Therapy (FFT/FFTCW), Homebuilders® or Multi-Systemic Therapy (MST) are excluded from the requirement to provide **medication management.** Such BHSPs shall develop policies and procedures to ensure:
    (a) screening of clients for medication management needs;
    (b) referral to appropriate community providers for medication management including assistance to the client/family to secure services; and
    (c) collaboration with the client's medication management provider as needed for coordination of the client's care.
2. BHSPs ***exclusively*** providing the evidence-based practice Functional Family Therapy (FFT/FFTCW), Homebuilders® or Multi-Systemic Therapy (MST) are excluded from the requirement of having a **Medical Director**. Such BHSPs shall

have a **Clinical Director** in accordance with Core Staffing 2. a. – c. of the Outpatient Services: Rehabilitation Services chapter of this manual.

Revision Details to Appendix E-2 Evidence Based Practices Functional Family Therapy/Functional Family Therapy – Child Welfare (FFT/FFT-CW) of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

June 2018
Revised to update provider qualifications and responsibilities to ensure compliance with current licensing requirements.
Publication date: 6/1/18
Effective in accordance with the licensing rule

Provider Qualifications and Responsibilities
FFT/FFT-CW agencies must adhere to all requirements established in the Provider Responsibilities section located in the Outpatient Services: Rehabilitation Services chapter of this manual.

EXCEPTIONS:

1. BHSPs ***exclusively*** providing the evidence-based practice Functional Family Therapy (FFT/FFTCW), Homebuilders® or Multi-Systemic Therapy (MST) are excluded from the requirement to provide **medication management.** Such BHSPs shall develop policies and procedures to ensure:
    (a) screening of clients for medication management needs;
    (b) referral to appropriate community providers for medication management including assistance to the client/family to secure services; and
    (c) collaboration with the client's medication management provider as needed for coordination of the client's care.
2. BHSPs ***exclusively*** providing the evidence-based practice Functional Family Therapy (FFT/FFTCW), Homebuilders® or Multi-Systemic Therapy (MST) are excluded from the requirement of having a **Medical Director**. Such BHSPs shall have a **Clinical Director** in accordance with Core Staffing 2. a. – c. of the Outpatient Services: Rehabilitation Services chapter of this manual.

Revision Details to Appendix E-3 Evidence Based Practices - HOMEBUILDERS® (HB)of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

June 2018

Revised to update provider qualifications and responsibilities to ensure compliance with current licensing requirements.
Publication date: 6/1/18
Effective in accordance with the licensing rule

Provider Qualifications and Responsibilities
Homebuilders® agencies must adhere to all requirements established in the Provider Responsibilities section located in the Outpatient Services: Rehabilitation Services chapter of this manual.

EXCEPTIONS:

1. BHSPs ***exclusively*** providing the evidence-based practice Functional Family Therapy (FFT/FFTCW), Homebuilders® or Multi-Systemic Therapy (MST) are excluded from the requirement to provide **medication management.** Such BHSPs shall develop policies and procedures to ensure:
    (a) screening of clients for medication management needs;
    (b) referral to appropriate community providers for medication management including assistance to the client/family to secure services; and
    (c) collaboration with the client's medication management provider as needed for coordination of the client's care.
2. BHSPs ***exclusively*** providing the evidence-based practice Functional Family Therapy (FFT/FFTCW), Homebuilders® or Multi-Systemic Therapy (MST) are excluded from the requirement of having a **Medical Director**. Such BHSPs shall have a **Clinical Director** in accordance with Core Staffing 2. a. – c. of the Outpatient Services: Rehabilitation Services chapter of this manual.

Revision Details to Appendix E-4 Evidence Based Practices Multi-Systemic Therapy (MST)of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

February 2021

Revisions made to update treatment plan expectations and supervision.
Publication date: 2/5/21

Treatment Planning

All treatment planning will be informed by an initial psychosocial assessment, which is completed by the MST Supervisor prior to entry into MST services. Use of the Child and Adolescent Level of Care Utilization System (CALOCUS) is not required for MST.

In the MST model, the MST therapist conducts treatment planning using the MST "Case Summary" process; for a member receiving MST services, the document titled "Initial Case Summary," and the documents which are updated each week as the "Weekly Case Summary," serve as the treatment plan for the member. The Initial Case Summary ~~treatment plan~~ is developed by the MST therapist, based on the assessment, youth and family strengths, ~~based on the~~ referral behaviors, and the goals of the youth and family. Goals of the youth, family, and other key participants in treatment (i.e., probation officer) are documented in the Case Summary as "Desired Outcomes of Key Participants," and these inform the "Overarching Goals" of treatment as documented in the Case Summary.

The Initial Case Summary is signed by the caregiver, and ideally signed by the youth as well. In the rare event that an MST treatment episode extended for over 180 days, the MST provider must obtain additional caregiver and youth signatures on the updated Case Summary at that time.

The Initial Case Summary is then continuously updated in the Weekly Case Summaries. ~~includes~~ Weekly Case Summaries are driven by continuous assessment, data collection and analysis, ~~documentation~~, team and supervisory input, goal development, intervention development and implementation, outcome assessment, and ongoing plan revision ~~and~~

~~termination~~. Overarching goals are established at the beginning of treatment, while specific objectives are updated each week and closely monitored in the Weekly Case Summaries. In each Weekly Case Summary, the MST therapist reviews the Overarching Goals, and then:

- Develops Intermediary Goals that are specific, measureable action-oriented, realistic, and time-limited objectives,
- Outlines intervention steps that will be taken to accomplish each Intermediary Goal
- Reviews previous Intermediary Goals, and
- Documents advances in treatment, to indicate progress being made, and ongoing assessment of barriers, which leads to development of new intermediary goals.

MST provides LMHP oversight over treatment planning through MST supervision and consultation, which includes weekly review of treatment planning between the MST clinician, MST supervisor, and MST consultant. Supervisor and consultant feedback will be integrated into the Weekly Case Summaries and will be implemented into the upcoming week's intervention plan.

Supervision

Weekly group supervision and consultation is documented on the MST Weekly Case Summaries, which document a weekly review of work on the case (goals, barriers, advances in treatment, ongoing assessment, and new goals) along with questions for supervision and consultation, and feedback received by the MST therapist from supervision and consultation.

Individual supervision of MST clinicians is not a requirement for an MST license through MST Services; within the MST model, group supervision is the preferred modality. However, effective July 15, 2020, all non-licensed providers of rehabilitation services under LA Medicaid (inclusive of non-licensed MST clinicians) are required to have **no less than one (1) hour of individual supervision,** as part of the overall requirement for a minimum of 4 hours of clinical supervision per month for non-licensed staff.

June 2018

Revised to update provider qualifications and responsibilities to ensure compliance with current licensing requirements.

Publication date: 6/1/18

Effective in accordance with the licensing rule

Provider Qualifications and Responsibilities

MST agencies must adhere to all requirements established in the Provider Responsibilities section located in the Outpatient Services: Rehabilitation Services chapter of this manual.

EXCEPTIONS:

1. BHSPs ***exclusively*** providing the evidence-based practice Functional Family Therapy (FFT/FFTCW), Homebuilders® or Multi-Systemic Therapy (MST) are excluded from the requirement to provide **medication management.** Such BHSPs shall develop policies and procedures to ensure:
    (a) screening of clients for medication management needs;
    (b) referral to appropriate community providers for medication management including assistance to the client/family to secure services; and
    (c) collaboration with the client's medication management provider as needed for coordination of the client's care.
2. BHSPs ***exclusively*** providing the evidence-based practice Functional Family Therapy (FFT/FFTCW), Homebuilders® or Multi-Systemic Therapy (MST) are excluded from the requirement of having a **Medical Director**. Such BHSPs shall have a **Clinical Director** in accordance with Core Staffing 2. a. – c. of the Outpatient Services: Rehabilitation Services chapter of this manual.

Revision Details to Appendix E-5 Evidenced Based Practices–Child/Parent Psychotherapy of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

July 2019

Clarification of billing code identifier on page 7.
Publication date: 7/1619

June 2019

New appendix added to the manual.
Publication date: 6/12/19

Revision Details to Appendix E-6 Evidenced Based Practices – Parent-Child Interaction Therapy of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

July 2019

Clarification of billing code identifier on page 7.
Publication date: 7/1619

June 2019

New appendix added to the manual.
Publication date: 6/12/19

Revision Details to Appendix E-7 Evidenced Based Practices – Preschool PTSD Treatment and Youth PTSD of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

July 2019

Clarification of billing code identifier on page 7.
Publication date: 7/1619

June 2019

New appendix added to the manual.
Publication date: 6/12/19

Revision Details to Appendix E-8 Evidenced Based Practices – Triple P Positive Parenting Program – Standard Level 4 of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

April 2020

New appendix added to the manual.
Publication date: 4/22/20

Revision Details to Appendix E-9 Evidenced Based Practices – Trauma-Focused Cognitive Behavioral Therapy of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

April 2020

New appendix added to the manual.

Publication date: 4/22/20

Revision Details to Appendix E-10 Evidence Based Practices – EMDR Therapy of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

June 2020

New appendix added to the manual.
Publication date: 6/30/20

Revision Details to Appendix F CSoC Wraparound Model of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

January 2021

Revisions made to clarify Wraparound Agency and staff qualification requirements.
Publication date: 1/5/21

WAA Qualification Requirements

• Arranges for and maintains documentation that all persons, prior to employment, pass criminal background checks ~~through the Louisiana Department of Public Safety, State Police~~ and a search of the U.S. Department of Justice National Sex Offender Registry. If the results of any criminal background check reveal that the potential employee (or contractor) was convicted of any offenses against a child/youth or an elderly or disabled person, the WAA provider shall not hire and/or shall terminate the employment (or contract) of such individual. The WAA 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. Criminal background accordance with La. R.S. 15:587 et seq. ~~Criminal background checks performed over 30 days prior to date of employment will not be accepted as meeting this requirement.~~

• The WAA shall not hire individuals failing to meet criminal background check requirements and regulations. Individuals not in compliance with criminal background check requirements and regulations shall not be utilized on an employment, contract nor volunteer basis. Criminal background checks performed over 30 days prior to the date of employment will not be accepted as meeting the criminal background check requirement. The WAA provider shall maintain the results of an individual's criminal background check in the individual's personnel record and comply with the confidentiality requirements of La. R.S. 40:1203.4.

• The WAA must review the Department of Health and Human Services' Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) and the LDH State Adverse Actions website prior to hiring or contracting any employee or contractor that performs services that are compensated with Medicaid/Medicare funds, including but

not limited to licensed and unlicensed staff, interns and contractors. Once employed, the lists must be checked once a month thereafter to determine if there is a finding that an employee or contractor has abused, neglected or extorted any individual or if they have been excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General. The OIG maintains the LEIE on the OIG website (https://exclusions.oig.hhs.gov) and the LDH Adverse Action website is located at https://adverseactions.ldh.la.gov/SelSearch.
• The WAA is prohibited from knowingly employing or contracting with, or retaining the employment of or contract with, anyone who has a negative finding placed on the Louisiana State Adverse Action List, or who have been excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General. The WAA provider shall maintain the results of completed searches in the LEIE and LDH State Adverse Action databases in the individual's personnel record.

WAA Staff Qualification Requirements

• Satisfactory completion of criminal background check pursuant to La. R.S. 40:1203.1 *et seq*., La R.S. 15:587 (as applicable), and any applicable state or federal law or regulation; ~~A criminal background check through the Louisiana Department of Public Safety, State Police and a search of the U.S. Department of Justice National Sex Offender Registry will be conducted prior to employment to ensure that the potential employee (or contractor) has not been convicted of any offenses against a child/youth or an elderly or disabled person and does not have a record as a sex offender. If the results of any criminal background check reveal that the potential employee (or contractor) was convicted of any offenses against a child/youth or an elderly or disabled person, the provider shall not hire and/or shall terminate the employment (or contract) of such 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. Criminal background checks must be performed as required by R.S. 40:1203 et seq., and in accordance with R.S. 15:587 et seq.;~~
• Employees and contractors must not be excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General;
• Staff must not have a finding on the Louisiana State Adverse Action List;
• ~~Pass a motor vehicle screen;~~
• Pass a TB test;
• Pass drug screening tests as required by WAA provider's ~~agency's~~ policies and procedures; and

• Complete AHA recognized First Aid, CPR and seizure assessment training. (Note: psychiatrists, APRNs/~~CNSs/~~PAs, registered nurses (RNs) and licensed practical nurses (LPNs) are exempt from this training.)

July 2018

Revised to remove the fingerprinting specifications on pages 12 and 14.
Publication date: 7/20/18
Effective date: October 6, 2017

'Revision Details to Appendix G - Standardized Assessments for Members Receiving CPST and PSR of the Behavioral Health Services Provider Manual

Revisions contained herein are the substantive changes made in the chapter. Underline denotes additions to the manual language. Strikethrough denotes language that has been removed.

Providers must be in compliance with any revisions within 60 days of the publication date unless an effective date is noted.

March 2018

New appendix added to the manual.
Publication date: 3/1/18