



BEHAVIORAL HEALTH SERVICES

Chapter Two of the Medicaid Services Manual

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**State of Louisiana
Bureau of Health Services Financing**

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OVERVIEW

Specialized behavioral health services (SBHS) are mental health services and substance use/addiction disorder services, specifically defined in the Medicaid State Plan and/or applicable waivers. These services shall be administered under the authority of the Louisiana Department of Health (LDH) in collaboration with the Healthy Louisiana plans, as well as through the Coordinated System of Care (CSoC) program contractor, for members enrolled in CSOC. SBHS are distinguished from basic behavioral health (BH) services offered by the Healthy Louisiana plans and the CSOC contractor. Basic BH services are mental health and substance use services which are provided to enrollees with emotional, psychological, substance use, psychiatric symptoms and/or disorders that are provided in the member’s primary care physician (PCP) office by the member’s PCP as part of primary care service activities.

This provider manual chapter outlines SBHS offered under Medicaid managed care, §1915(c) and §1915(b) waiver services offered only through the CSOC program contractor, as well as other SBHS offered to CSOC children and Medicaid members enrolled in a Healthy Louisiana plan. Service limitations, utilization, allowed provider types and specialties, and eligibility criteria are covered for services within the chapter.

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 SBHS 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 BH 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.

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:

1. Delivered in a culturally and linguistically competent manner;
2. Respectful of the individual receiving services;
3. Appropriate to individuals of diverse racial, ethnic, religious, sexual and gender identities and other cultural and linguistic groups; and

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4. Appropriate for age, development; and education.

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.

CHAPTER 2: BEHAVIORAL HEALTH SERVICES**SECTION 2.1: PROVIDER REQUIREMENTS****PAGE(S) 1****PROVIDER REQUIREMENTS**

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 members in Medicaid's Fee for Service program (non-Managed Care), or to Medicaid members 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 the Louisiana Department of Health (LDH) Information Bulletin 15-17 posted at <http://ldh.la.gov/index.cfm/page/1198>.

Providers should refer to Chapter 1 – General Information and Administration of the *Medicaid Services Manual* for additional information on provider enrollment and requirements, including general standards for participation. (See Appendix A for information on accessing Chapter 1).

Healthy Louisiana managed care organizations (MCOs) and the Coordinated System of Care (CSoC) contractor are responsible for ensuring providers with whom they contract to provide specialized behavioral health services (SBHS), meet the minimum qualification requirements in accordance with the below provisions, all applicable state and federal laws, rules and regulations, and Centers for Medicare and Medicaid Services' (CMS) approved waivers and Medicaid State Plan amendments.

Licensure and Specific Provider Requirements

Providers must meet licensure and/or certification requirements, as well as other additional requirements as outlined in the sections below:

Section	Subject	Topic
2.2	Bed-Based Services	Therapeutic Group Homes
2.2	Bed-Based Services	Psychiatric Residential Treatment Facilities
2.3	Outpatient Services	Behavioral Health Services in a Federally Qualified Health Center or Rural Health Clinic
2.3	Outpatient Services	Outpatient Therapy by Licensed Practitioners
2.3	Outpatient Services	Rehabilitation Services for Children, Adolescents, and Adults
2.3	Outpatient Services	Peer Support Services
2.4	Addiction Services	Same

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Bed Based Services**Crisis Stabilization for Adults**

Crisis Stabilization (CS) for adults is a short-term bed-based crisis treatment and support service for members who have received a lower level of crisis services and are at risk of hospitalization or institutionalization, including nursing home placement. CS is utilized when additional crisis supports are necessary to stabilize the crisis and ensure community tenure in instances in which more intensive inpatient psychiatric care is not warranted or when the member's needs are better met at this level. CS operates 24 hours a day, seven days a week as short-term mental health crisis response, offering a voluntary home-like alternative to more restrictive settings, such as the emergency departments, or coercive approaches, such as Physician Emergency Certificates (PECs), law enforcement holds, or Orders of Protective Custody (OPCs). This voluntary service is designed to ameliorate a psychiatric crisis and/or reduce acute symptoms of mental illness and to provide crisis relief, resolution, and intensive supportive resources for adults who need intensive temporary support and is not intended to be a housing placement.

CS assists with deescalating the severity of a member's level of distress and/or need for urgent care associated with a mental health disorder. The goal is to support members in ways that will mitigate the need for higher levels of care, further ensuring the coordination of a successful return to community placement at the earliest possible time. Short-term crisis bed based stabilization services include a range of resources that can meet the needs of the member with an acute psychiatric crisis and provide a safe environment for care and recovery. Care coordination is a key element of crisis services, coordinating across the services and beyond depending on the needs of the member.

Services are provided in an organized bed-based non-medical setting, delivered by appropriately trained staff that provide safe 24-hour crisis relieving/resolving intervention and support, medication management, observation and care coordination in a supervised environment where the member is served. While these are not primary substance use treatment facilities, the use of previously initiated medication assisted treatment (MAT) may continue.

Components**Assessment**

1. The psychiatric diagnostic evaluation of risk, mental status and medical stability must be conducted by a licensed mental health professional (LMHP) or psychiatrist with experience regarding this specialized mental health service and practicing within the scope of their professional license. This assessment should build upon what is learned by previous crisis response providers or the Assertive Community Treatment (ACT) provider and should include contact with the

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member, family members or other collateral sources (e.g., caregiver, school personnel) with pertinent information for the purpose of the evaluation and/or referral to and coordination with other alternative behavioral health services at an appropriate level. If the member expressly refuses to include family or other collateral sources, it must be documented in the member record. If a psychiatric diagnostic evaluation was completed within 30 days, another evaluation does not need to be completed at this time, but an update to capture the member's current status must be added to the previous evaluation; and

2. A registered nurse (RN) or licensed practical nurse (LPN) practicing within the scope of their license performs a medical screen to evaluate for medical stability.

Interventions

1. The intervention is driven by the member and is developed by the LMHP, psychiatrist, or non-licensed staff in collaboration with the LMHP or the psychiatrist building on and updating the strategies developed by the mobile crisis response (MCR), behavioral health crisis care (BHCC), and/or community brief support service (CBCS) service providers. Through this process, short-term goals are set to ensure stabilization, symptom reduction and restoration to a previous level of functioning.

Intervention should be developed with input from the member, family and other collateral sources. Strategies are developed for the member to use post current crisis to mitigate risk of future incidents until the member engages in alternative services, if appropriate.

2. The service will include brief interventions using person centered approaches, such as, crisis resolution, self-help skills, peer support services, social skills, medication support, and co-occurring substance use disorder treatment services through individual and group interventions. Service must be provided under the supervision of an LMHP or psychiatrist with experience regarding this specialized behavioral health service;
3. Substance use should be recognized and addressed in an integrated fashion, as it may add to the risk, increasing the need for engagement in care; and
4. Support, education, and consultation is provided to the member, family, and collateral supports.

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Care Coordination

CS providers shall coordinate care for the member following the crisis event as needed. Care coordination includes the following activities:

1. Coordinating the transfer to alternate levels of care within 24 hours when warranted, including but not limited to:
 - a. **Primary medical care** - Member requires primary medical care with an existing provider;
 - b. **Community based behavioral health provider** - Member requires ongoing support at a lower level of care with the member's existing behavioral health provider. The member should return to existing services as soon as indicated and accessible;
 - c. **Community Brief Crisis Support (CBCS)** - Member requires ongoing support at home or in the community, if the member does not have an existing behavioral health provider who can meet their current critical needs as defined in the discharge plans;
 - d. **Crisis Stabilization (CS)** – Member may need additional time outside of the home without being at immediate risk for inpatient treatment due to experiencing severe intoxication or withdrawal episodes that cannot be managed safely in this setting, at immediate suicide risk, or currently violent;
 - e. **Inpatient treatment** – Member is in medical crisis, experiencing severe intoxication or withdrawal episodes, or is actively suicidal, homicidal, gravely disabled, or currently violent; and
 - f. **Residential substance use treatment** - Member requires ongoing support outside of the home for a substance use disorder.

NOTE: Crisis care should continue until the crisis is resolved and the member no longer needs crisis services. Readiness for discharge is evaluated on a daily basis.

2. Coordinating contact through a warm handoff with the member's managed care organization (MCO) managed care entity (MCE) to link the member with no current behavioral health provider and/or primary medical care provider to outpatient services as indicated;

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3. Coordinating contact through a warm handoff with the member’s existing or new behavioral health provider; and
4. Providing any member records to the existing or new behavioral health provider or to another crisis service to assist with continuing care upon referral.

Follow-Up

Provide follow up to the member and authorized member’s caretaker and/or family up to 72 hours to ensure continued stability post crisis for those not accessing CBCS or higher levels of care, including but not limited to:

1. Telephonic follow-up based on clinical individualized need; and
2. Additional calls/visits to the member following the crisis unless the member indicates no further communication is desired as documented in the member’s record.

Eligibility Criteria

The medical necessity for these rehabilitative services must be determined by and recommended by an LMHP or physician to promote the maximum reduction of symptoms and/or restoration of an individual to their best age-appropriate functional level. Referrals to CS must be completed by the MCR, BHCC, CBCS providers or ACT teams.

Other referrals will be considered on a case by case basis. This service is intended for any member in mental health crisis, needing immediate intervention to stabilize the situation and needing help now but is whose needs do not meet a higher level of care (examples include not at medical risk or currently violent).

While medical clearance will not be required, members admitted to this level of care should be medically stable. Members who have a co-morbid physical condition that requires nursing or hospital level of care or who are a threat to themselves or others and require an inpatient level of care are not eligible for CS services.

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Service Utilization

CS requires concurrent review after the initial 24-hour period, is based on medical necessity, and is intended to assure ongoing access to medically necessary crisis response services and supports until the current crisis is resolved, or until the member can access alternative behavioral health supports and services. The CS provider must immediately notify the MCE of the member’s admission. The member’s treatment record must reflect relief, resolution and problem solving of the identified crisis or referral to an alternate provider.

The LMHP or psychiatrist must be available at all times to provide back up, support and/or consultation through all services delivered during a crisis.

NOTE: Such encounters will be subject to retrospective review. In this way, IF it is determined that the available/reviewed documentation does **not** support the crisis, the payment may be subject to recoupment.

Service Delivery

All mental health services must be medically necessary in accordance with the Louisiana Administrative Code 50:I.1101. The medical necessity for services shall be determined by an 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:

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

Allowed Modes of Delivery

1. On-site

Provider Responsibilities

1. All services shall be delivered in accordance with federal and state laws and regulations, the applicable Louisiana Medicaid Provider manual and other notices

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or directives issued by the Department. The provider shall create and maintain documents to substantiate that all requirements are met. (See Section 2.6 Record Keeping);

2. Any licensed practitioner providing behavioral health services must operate within the scope of practice of their license; and
3. Provider shall maintain treatment records that include the name of the individual, a treatment plan, the dates of services provided, the nature and content of the services provided, and progress made toward functional improvement and goals in the treatment plan.

Supervision of Non-Licensed Staff

Crisis Stabilization providers must employ at least one LMHP or psychiatrist to specifically serve as a clinical supervisor to assist in the design and evaluation of crisis planning and crisis stabilization services. LMHPs serving in the role of clinical supervisor 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. The supervisor must be available for supervision responsibilities 24 hours a day and seven days a week to respond to supervision needs of non-licensed staff responding to crises.

Services provided by non-licensed staff 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)) or a psychiatrist. LMHP or psychiatrist supervisors must have the practice-specific education, experience, training, credentials, and licensure to coordinate an array of mental and/or behavioral health services. Providers may have more than one LMHP or psychiatrist supervisor providing required clinical supervision to non-licensed staff.

1. 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;
2. Staff shall receive a minimum of **four** hours of clinical supervision per month for full time staff and a minimum of **one** hour of clinical supervision per month for part time staff, which shall consist of **no less than one hour of individual supervision**. Each month, the remaining hours of supervision may be in a group

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setting. Given consideration of case load and acuity, additional supervision may be indicated;

3. LMHP (excluding LACs) or the psychiatrist supervisor must ensure services are in compliance with the established requirements of this service;
4. Group supervision means one LMHP (excluding LACs) or psychiatrist supervisor and not more than six supervisees in supervision session.;
5. Maximum of 75 percent of the individual and group supervision 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; and
6. Supervision with the LMHP or psychiatrist must:
 - a. Have intervention notes that are discussed in supervision must have the LMHP or psychiatrist supervisor's signature; and
 - b. Have documentation reflecting the content of the training and/or clinical guidance. The documentation must include the following:
 - i. Date and duration of supervision;
 - ii. Identification of supervision type as individual or group supervision;
 - iii. Name and licensure credentials of the LMHP or psychiatrist supervisor;
 - iv. Name and credentials (provisionally licensed, master's degree, bachelor's degree, or high school degree) of the supervisees;
 - v. The focus of the session and subsequent actions that the supervisee must take;
 - vi. Date and signature of the LMHP or psychiatrist supervisor;
 - vii. Date and signature of the supervisees; and
 - viii. Start and end time of each supervision session.

Reporting Requirements

The provider shall comply with data collection and reporting requirements as specified by LDH.

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Provider Qualifications

Facility

To provide crisis stabilization services, facilities must:

1. Be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or The Joint Commission (TJC). Denial, loss of, or any negative change in accreditation status must be reported in writing immediately upon notification to the managed care entities with which the facility contracts or is being reimbursed;

NOTE: Facilities must apply for accreditation and pay accreditation fees prior to being contracted and reimbursed by a MCE, and must maintain proof of the accreditation application and associated fee payment. Facilities must attain full accreditation within 12 months of the initial accreditation application date.

2. Have a minimum capacity of four beds and a maximum capacity of 16 beds;
3. Arrange for and maintain documentation that all persons prior to employment (or contracting, volunteering, or as required by law), have passed criminal background checks , including sexual offender registry checks, by an agency authorized by the Office of State Police to conduct criminal background checks in accordance with the Crisis Receiving Center Level III licensing regulations established by the Louisiana Administrative Code 48:I.Chapter 53:

Criminal background checks must be performed as required by La. R.S. 40:1203.1 et seq., in accordance with La. R.S. 15:587 et seq, and any other applicable state or federal law. Criminal background checks performed over ninety (90) days prior to date of employment will not be accepted as meeting this requirement.

4. 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 or volunteer basis;
5. Criminal background checks performed over ninety (90) days prior to the date of employment will not be accepted as meeting the criminal background check requirements. Results of criminal background checks are to be maintained in the individual’s personnel record;

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6. 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 with any employee or contractor who performs services that are compensated with Medicaid/Medicare funds, including but not limited to licensed and non-licensed staff, interns and contractors:
 - a. Once employed, check the list monthly thereafter to determine if there is a finding that an employee or contractor has abused, neglected or extorted any individual or if employee or contractor has 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; and
 - b. 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 the Department of Health and Human Services’ Office of Inspector General.
7. Maintain results in personnel records that these 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>;
8. Arrange for and maintain documentation that all persons, prior to employment, are free from Tuberculosis (TB) in a communicable state as defined by the Louisiana Administrative Code 51:II.Chapter 5 to reduce the risk of such infections in recipients and staff. Results from testing performed over 30 days prior to the date of employment will not be accepted as meeting this requirement;
9. Establish and maintain written policies and procedures inclusive of drug testing staff to ensure an alcohol and drug-free workplace and a workforce free of substance use. (See Appendix D);

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10. Maintain documentation that all direct care staff, who are required to complete First Aid, cardiopulmonary resuscitation (CPR) and seizure assessment training, complete American Heart Association (AHA) recognized training within 90 days of hire, which shall be renewed within a time period recommended by the AHA. Psychiatrists, APRNs/physician assistants (Pas), RNs and LPNs are exempt from this training. (See Appendix D);
11. Maintain a personnel file for each employee, contractor, and individual with whom the facility has 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;
12. Maintain documentation for verification of completion of required trainings for all staff; and
13. Ensure and maintain documentation that all persons employed by the organization complete training in the OBH approved Crisis Response curriculum. (See Appendix D).

Staff

To provide crisis stabilization services, staff must meet the following requirements:

1. Must be at least 24 years of age;
2. Unlicensed staff must have a minimum of bachelor's degree (preferred) **or** an associate's degree and two years of work experience in the human services field **or** meet recognized peer support specialist (RPSS) qualifications. (See Section 2.3 Outpatient Services - Peer Support Services);
3. Satisfactory completion of criminal background checks pursuant to the applicable provider license type issued by Louisiana Department of Health (LDH) - Health Standards, La R.S. 40:1203.1 *et seq.*, and any applicable state or federal law or regulation;
4. 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' OIG;
5. Direct care staff must not have a finding on the Louisiana State Adverse Action List;

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- a. Pass a Tuberculosis (TB) test prior to employment in accordance with the Louisiana Administrative Code 51:II.Chapter 5; OR be free from TB in a communicable state as defined by the Louisiana Administrative Code 51:II.Chapter 5.
6. Pass drug screening tests as required by the facility's policies and procedures;
7. Complete American Heart Association (AHA) recognized First Aid, CPR and seizure assessment training. Psychiatrists, APRNs/PAs, RNs and LPNs are exempt from this training. (See Appendix D);
8. Comply with Direct Service Worker Registry law established by La. R.S. 40:2179 *et seq.* and meet any additional qualifications established under Rule promulgated by LDH in association with this statute;
9. Non-licensed direct care staff are required to complete a basic clinical competency training program approved by OBH prior to providing the service. (See Appendix D); and
10. Complete training curriculum approved by OBH prior to providing the service. (See Appendix D).

The RPSS 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). (See the Section 2.3 Outpatient Services - Peer Support Services).

Staffing Requirements

The facility shall comply with the minimum staffing requirements in accordance with federal and state laws and regulations. In addition, the following core staffing requirements must be followed:

1. RPSS on duty adequate to meet the member's needs;
2. Staffing must be sufficient that there are at least two staff present at all time; and
3. A staff to member ratio of 1:4 must be maintained at all times. Staffing should take into consideration the health and safety of the members and staff.

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Allowed Provider Types and Specialties

1. PT AF Crisis Receiving Center, PS 8E CSoC/Behavioral Health.

Limitations/Exclusions

The following services shall be excluded from Medicaid coverage and reimbursement:

1. Services rendered in an institute for mental disease; and
2. Cost of room and board.

Crisis stabilization shall not duplicate any other Medicaid State Plan service or service otherwise available to the member at no cost.

The per diem for CS and BHCC cannot be billed on the same day.

Restraints and seclusion cannot be used in CS.

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Crisis Stabilization for Youth

Crisis stabilization is intended to provide short-term and intensive supportive resources for the youth and their family. The intent of this service is to provide an out-of-home crisis stabilization option for the family in order to avoid psychiatric inpatient and institutional treatment of the youth by responding to potential crisis situations. The goal will be to support the youth and family in ways that will address current acute and/or chronic mental health needs and coordinate a successful return to the family setting at the earliest possible time. During the time the crisis stabilization is supporting the youth, there is regular contact with the family to prepare for the youth's return and their ongoing needs as part of the family. It is expected that the youth, family and crisis stabilization provider are integral members of the youth's individual treatment team.

Transportation is provided between the child/youth's place of residence, other services sites and places in the community. The cost of transportation is included in the rate paid to providers of these services.

Medicaid cannot be billed for the cost of room and board. Other funding sources reimburse for room and board, including the family or legally responsible party (e.g., Office of Juvenile Justice (OJJ) and Department of Children and Family Services (DCFS)).

Components

The components of CS services are as follows:

1. A preliminary assessment of risk, mental status and medical stability and the need for further evaluation or other mental health services must be conducted. This includes contact with the member, family members or other collateral sources (e.g., caregiver, school personnel) with pertinent information for the purpose of a preliminary assessment and/or referral to other alternative mental health services at an appropriate level;
2. CS includes out of home short-term or extended intervention for the identified Medicaid-eligible individual based on initial and ongoing assessment of needs, including crisis resolution and debriefing;
3. CS includes follow up with the individual and with the individual's caretaker and/or family members; and

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4. CS includes consultation with a physician or with other qualified providers to assist with the individual’s specific crisis.

CS Provider Qualifications

Agency

To provide crisis stabilization services, the agency must arrange 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:

1. 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;
2. La. R.S. 40:1203.1 *et seq.* associated with criminal background checks of un-licensed workers providing patient care;
3. La. R.S. 15:587, as applicable; and
4. Any other applicable state or federal law:
 - a. 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;
 - b. 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

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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;

NOTE: 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>.

- c. Arrange for and maintain documentation that all persons, prior to employment, are free from Tuberculosis (TB) in a communicable state via skin testing (or chest exam if recommended by physician) to reduce the risk of such infections in members and staff. Results from testing performed over thirty (30) days prior to date of employment will not be accepted as meeting this requirement;
- d. Establish and maintain written policies and procedures inclusive of drug testing staff to ensure an alcohol and drug-free workplace and a workforce free of substance use. (See Appendix D);
- e. Maintain documentation that all direct care staff, who are required to complete first aid, cardiopulmonary resuscitation (CPR) and seizure assessment training, complete American Heart Association (AHA) recognized training within 90 days of hire, which shall be renewed within a time period recommended by the AHA. (See Appendix D);
- f. Ensure and maintain documentation that all non-licensed persons employed by the organization complete a documented training in a recognized Crisis Intervention curriculum prior to handling or managing crisis calls, which shall be updated annually;
- g. Maintain documentation for verification of completion of required trainings for all staff;

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- h. Be an agency licensed by the Louisiana Department of Health (LDH) or the Department of Children and Family Services (DCFS);
- i. Maintain treatment records that include a copy of the 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; and
- j. Supervise the direct service workers (DSWs) that provide the care members receive.

The DSW’s ability to perform their assigned duties in order to:

- 1. Determine whether member is receiving the services that are written in the plan of care;
- 2. Verify that the DSW is actually reporting to the home according to the frequency ordered in the plan of care; and
- 3. Determine member’s satisfaction with the services member is receiving.

Staff

To provide crisis stabilization services, staff must meet the following requirements:

- 1. Be at least 18 years of age, and at least three years older than an individual under the age of 18 that they provide services;
- 2. Have a high school diploma, general equivalency diploma or trade school diploma in the area of human services, or demonstrate competency or verifiable work experience in providing support to persons with disabilities;

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

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supports the individual's academic program required at least seventy percent (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.

3. Satisfactorily complete 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;
4. 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;
5. Direct care staff must not have a finding on the Louisiana State Adverse Action List;
6. Pass a tuberculosis (TB) test prior to employment;
7. Pass drug screening tests as required by agency's policies and procedures;
8. Complete American Heart Association (AHA) recognized first aid, CPR and seizure assessment training. Psychiatrists, APRNs/CNSs/PAs, RNs and LPNs are exempt from this training. (See Appendix D);
9. Pass a motor vehicle screen;
10. Possess and provide documentation of a valid social security number;
11. Provide documentation of current cardiopulmonary resuscitation (CPR) and first aid certifications;
12. Comply with law established by La. R.S. 40:2179 *et seq.*, and meet any additional qualifications established under Rule promulgated by LDH in association with this statute;

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13. Use clinical programming and a training curriculum approved by OBH prior to providing the service; and
14. Operate within their scope of practice license required for the facility or agency to practice in the State of Louisiana.

CS Allowed Provider Types and Specialties**1. Center Based Respite Care**

- a. Licensed as a home and community-based services (HCBS) provider/ Center-Based Respite per La. R.S. 40:2120.1 *et seq.* and Louisiana Administrative Code (LAC) 48:I.Chapter 50 found at the following website: <http://www.doa.la.gov/Pages/osr/lac/Code.aspx>;
- b. Completion of State-approved training according to a curriculum approved by OBH prior to providing the service. (See Appendix D); and
- c. PT 83 Center Based Respite Care, PS 8E CSoC/Behavioral Health.

2. Crisis Receiving Center

- a. Licensed per La. R.S. 40:2180.12 and LAC 48:I. Chapters fifty-three (53) and fifty-four (54) found at the following website: <http://www.doa.la.gov/Pages/osr/lac/Code.aspx>;
- b. Completion of State-approved training according to a curriculum approved by OBH prior to providing the service. (See Appendix D); and
- c. PT AF Crisis Receiving Center, PS 8E CSoC/Behavioral Health.

3. Child Placing Agency (Therapeutic Foster Care)

- a. Licensed as a Child Placing Agency by Department of Children and Family Services under the Specialized Provider Licensing Act (La. R.S. 46:1401-46:1430) and LAC 67:V.Chapter 73, found at the following website: [Residential Licensing Forms | Louisiana Department of Children & Family Services](#);

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- b. Completion of State-approved training according to a curriculum approved by OBH prior to providing the service. (See Appendix D); and
- c. PT AR Therapeutic Foster Care, PS 9F Therapeutic Foster Care.

CS Limitations/Exclusions

The following services shall be excluded from Medicaid coverage and reimbursement:

- 1. Services rendered in an institute for mental disease; and
- 2. The cost of room and board. The minimum daily rate on file is an all-inclusive rate.

Crisis stabilization shall not be provided simultaneously with short-term respite care and shall not duplicate any other Medicaid State Plan service or service otherwise available to the member at no cost.

CS Allowed Mode(s) of Delivery

- 1. Individual; and
- 2. On-site.

Bed Based Services

Therapeutic Group Homes

Therapeutic group homes (TGHs) provide a community-based residential service in a home-like setting of no greater than ten beds, for members under the age of 21, who are under the supervision and program oversight of a psychiatrist or psychologist. TGHs are located in residential communities in order to facilitate community integration through public education, recreation and maintenance of family connections.

TGHs deliver an array of clinical and related services within the home, including psychiatric supports, integration with community resources and skill-building taught within the context of the home-like setting. The treatment should be targeted to support the restoration of adaptive and functional behaviors that will enable the child or adolescent to return to and remain successfully in their home and community, and to regularly attend and participate in work, school or training, at the child's best possible functional level.

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

The setting shall be geographically situated to allow ongoing participation of the child's family. In this setting, the child or adolescent remains involved in community-based activities and attends a community educational, vocational program or other treatment setting.

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The supervising practitioner should review the referral *Pretreatment Assessment* at admission or within 72 hours of admission and prior to service delivery.

Assessment and Treatment Planning

The supervising practitioner must complete an initial diagnostic assessment at admission or within 72 hours of admission and prior to service delivery and must provide face to face assessment of the member at least every 28 days or more often as necessary per LAC I:42, chapter 62.

Assessments shall be completed with the involvement of the child or adolescent and the family and support system, to the extent possible. A standardized assessment and treatment planning tool must be used such as the Child and Adolescent Needs and Strengths (CANS) Comprehensive Assessment. The assessment protocol must differentiate across life domains, as well as risk and protective factors, sufficiently so that a treatment plan can be tailored to the areas related to the presenting problems of each youth and their family in order to ensure targeted treatment. The tool should also allow tracking of progress over time. The specific tools and approaches used by each program must be specified in the Program Description; please reference the “Program Requirements” section below, for further information about the Program Description. The TGH must ensure that youth are receiving appropriate therapeutic care to address assessed needs on the child’s treatment plan.

Within seven days of admission, a comprehensive treatment plan shall be developed by the established multidisciplinary team of staff providing services for the member. Each treatment team member shall sign and indicate their attendance and involvement in the treatment team meeting. The treatment team review shall be directed and supervised by the supervising practitioner at a minimum of every 28 days.

Treatment

Treatment provided in the TGH or in the community should incorporate research-based approaches appropriate to the child’s needs, whenever possible. The family/guardian should be involved in all aspects of treatment and face to face meetings as much as possible. Family

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members should be provided assistance with transportation and video conferencing options to support their engagement with the treatment process.

The individualized, strengths-based services and supports must meet the following criteria:

1. Be identified in partnership with the child or adolescent and the family and support system, to the extent possible;
2. Be implemented with oversight from a licensed mental health professional (LMHP);
3. Be based on both clinical and functional assessments;
4. Assist with the development of skills for daily living, and support success in community settings, including home and school;
5. Focus on reducing the behavior and symptoms of the psychiatric disorder that necessitated the removal of the child or adolescent from their usual living situation;
6. Decrease problem behavior and increase developmentally appropriate, normative and pro-social behavior in children and adolescents who are in need of out-of-home placement. As much as possible, this work should be done with the engagement of, and in the context of the family with whom the youth will live next, such that the skills learned to increase pro-social behavior are practiced within family relationships and so can be expected to generalize to the youth's next living situation;
7. Transition the child or adolescent from TGH to home- or community-based living, with outpatient treatment (e.g., individual and family therapy);
8. Care coordination is provided to plan and arrange access to a range of educational and therapeutic services; and
9. Psychotropic medications should be used with specific target symptoms identification, with medical monitoring and 24-hour medical availability when appropriate and relevant.

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Discharge Planning

Discharge planning begins on the day of admission using the TGH treatment episode to facilitate helping the youth progress towards be able to successfully reintegrate into a family setting. Discharge planning should be guided by the family/guardian and should identify and coordinate aftercare services and supports that will help the youth maintain safe and healthy functioning in a family environment.

Eligibility Criteria

The medical necessity for these rehabilitative services must be determined by and recommended by an LMHP or physician to promote the maximum reduction of symptoms and/or restoration of an individual to their best age-appropriate functional level.

Less intensive levels of treatment must have been determined to be unsafe, unsuccessful, or unavailable. The child under the age of 21 must require active treatment provided on a 24-hour basis with direct supervision/oversight by professional behavioral health staff that would not be able to be provided at a less restrictive level of care.

Allowed Mode(s) of Delivery

1. On-site.

Provider Responsibilities

The provider must comply with all responsibilities as outlined in the licensing regulations (LAC Title 48 Part 1, Chapter 62):

1. TGHs provide a twenty-four (24) hours/day, seven (7) days/week, structured and supportive living environment;
2. Although the psychologist or psychiatrist does not have to be on the premises when the member is receiving covered services, the supervising practitioner must assume accountability to direct the care of the member at the time of admission and during the entire TGH stay; and assure that the services are medically appropriate; and
3. The psychiatrist or psychologist/medical psychologist must provide twenty-four (24) hour, on-call coverage seven (7) days a week.

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

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

Provider Qualifications

Agency

Facilities that operate as TGHs must be licensed by the Louisiana Department of Health (LDH), in accordance with LAC 48:1, Chapter 62, to provide community-based residential services in a home-like setting of no greater than ten beds, and under the supervision and oversight of a psychiatrist or licensed psychologist, to children under the age of 21. A TGH must be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or The Joint Commission (TJC). Denial, loss of, or any negative change in accreditation status must be reported in writing immediately upon notification to the managed care entities with which the agency contracts or is being reimbursed.

NOTE: Facilities must apply for accreditation and pay accreditation fees prior to being contracted 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.

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

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manner to comply with the ten bed per facility limit (i.e., renovations of existing facilities exceeding ten beds must include a reduction in the bed capacity to ten beds).

TGH staff must be supervised by a licensed mental health professional (LMHP) with experience in evidence-based treatments and operating within their scope of practice license. LMHP staff also provide individual, family, and group therapy. Staff includes paraprofessional and bachelor’s level staff (who provide integration with community resources, skill building and peer support services) and master’s level staff (who provide individual, group, and family interventions) with degrees in social work, counseling, psychology or a related human services field, with oversight by a psychologist or psychiatrist. The human service field is defined as an academic program with a curriculum content in which at least 70 percent of the required courses are in the study of behavioral health or human behavior. A TGH must provide the minimum amount of active treatment hours established by the Department, and performed by qualified staff per week for each child, consistent with each child’s treatment plan and meeting assessed needs.

Facilities that operate as TGHs must meet the following criteria:

1. Arrange for and maintain documentation that prior to employment (or contracting, volunteering, or as required by law) individual’s pass the enhanced criminal background checks, including sexual offender registry checks, in accordance with all of the below:
 - a. The Therapeutic Group Homes (licensing regulations established by the Louisiana Administrative Code (LAC) 48:I. Chapter 62, which includes those for owners, managers, and administrators; and all employees or non-employees, including independent contractors, consultants, students, volunteers, trainees, or any other associated person, who performs paid or unpaid work with or for the TGH;
 - b. La. R.S. 40:1203.1 et seq. associated with criminal background checks of un-licensed workers providing patient care;
 - c. La. R.S. 15:587, as applicable; and
 - d. Any other applicable state or federal law.

NOTE: The enhanced criminal background check described in LAC 48:1, Chapter 62, §6210 is now required for each TGH, pursuant to the federal Family First Prevention Services Act (Public Law 115-123 enacted February 9, 2018) on child

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care institutions and Act 243 of the 2019 Regular Session of the Louisiana Legislature. This new enhanced criminal background check process encompasses the state requirements in R.S. 40:1203.1 et seq. A TGH's compliance with this new enhanced criminal background check process will be deemed in compliance with the requirements in R.S. 40:1203.1.

2. Not hire individuals failing to meet enhanced criminal background check requirements and regulations. Individuals not in compliance with the enhanced 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;
3. 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;
4. Maintain results in personnel records that checks have been completed. The OIG maintains the LEIE on the OIG website (<http://exclusions.oig.hhs.gov>) and the LDH Adverse Action website (<https://adverseactions.ldh.la.gov/SelSearch>);
5. Arrange for and maintain documentation that all persons, prior to employment, are free from tuberculosis (TB) in a communicable state via skin testing (or chest exam if recommended by physician) to reduce the risk of such infections in members and

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staff. Results from testing performed over 30 days prior to date of employment will not be accepted as meeting this requirement;

6. Establish and maintain written policies and procedures inclusive of drug testing staff to ensure an alcohol and drug-free workplace and a workforce free of substance use (See Appendix D in this manual chapter);
7. Maintain documentation that all direct care staff, who are required to complete first aid, and cardiopulmonary resuscitation (CPR) training, complete the training within 90 days of hire;
8. Maintain documentation of verification of staff meeting educational and professional requirements, licensure (where applicable), as well as completion of required trainings for all staff; and
9. Ensure and maintain documentation that all unlicensed persons employed by the organization complete training in a recognized crisis intervention curriculum prior to handling or managing crisis calls, which must be updated annually.

Program Requirements

All programs should incorporate some form of research-based, trauma-informed programming and training. TGH programs must have all research-based programming incorporated into a Program Description. As noted above in the “Assessment and Treatment Planning” section, specific assessment tools and approaches used by each program must also be specified in the Program Description. The Program Description must be approved by the program’s contracted managed care organizations (MCOs) as part of the credentialing and re-credentialing process or whenever changes are made, subject to OBH review.

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.

TGH facilities may specialize and provide care for sexually maladaptive behaviors, substance use or dually diagnosed members. If a program provides care to any of these categories of youth, the program must submit documentation as part of their program description regarding the appropriateness of the research-based, trauma-informed programming and training, as well as

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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).

Staff

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

1. Must be consistent with State licensure regulations. For example, if State licensure requires a ratio of not less than one staff to five members be maintained at all times; then, two staff must be on duty at all times with at least one being direct care staff when there is a member present;
2. Direct care staff must be at least 18 years old and at least three years older than an individual under 18 years of age;
3. Must have a high school diploma, general equivalency diploma or trade school diploma in the area of human services, or demonstrate competency or verifiable work experience in providing support to persons with disabilities. The human service field is defined as an academic program with a curriculum content in which at least 70 percent of the required courses are in the study of behavioral health or human behavior;
4. Must have a minimum of two years of experience working with children, be equivalently qualified by education in the human services field, or have a combination of work experience and education with one year of education substituting for one year of experience;
5. 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;

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6. Direct care staff must not have a finding on the Louisiana State Adverse Action List;
7. All unlicensed staff must be under the supervision and oversight of a psychiatrist or psychologist;
8. Pass criminal background check through DPS State Police prior to employment;
9. Pass a TB test prior to employment;
10. Pass drug screening tests as required by agency’s policies and procedures; and
11. Complete American Heart Association (AHA) recognized First Aid, and CPR training. Psychiatrists, advanced practical registered nurses (APRNs)/physician assistants (PAs), registered nurses (RNs) and licensed practical nurses (LPNs) are exempt from this training. (See Appendix D of this manual chapter).

Allowed Provider Types and Specialties

1. PT AT Therapeutic Group Home PS 5X Therapeutic Group Home.

Service Exclusions

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

1. Components that are not provided to or directed exclusively toward the treatment of the Medicaid eligible member;
2. Services provided at a work site which are job tasks oriented and not directly related to the treatment of the member’s needs;
3. Any services or components in which the basic nature of which are to supplant housekeeping, homemaking, or basic services for the convenience of a member receiving substance use treatment services;
4. Services rendered in an institution for mental disease (IMD);

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- 5. Room and board; and
- 6. Supervision associated with the child’s stay in the TGH.

Reimbursement

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

TGH services will be inclusive of, but not limited to, the allowable cost of clinical and related services, psychiatric supports, integration with community resources and the skill-building provided by unlicensed practitioners.

In addition to the Medicaid per diem rate for treatment services, there is also a separate per diem room and board component to the rate that cannot be paid with Medicaid funds. This room and board rate is typically paid by the youth’s custodian (in some cases a child-serving state agency) or another designated payment source.

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

TGH Cost Reporting Requirements

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

Bed Based Services

Psychiatric Residential Treatment Facilities

Psychiatric residential treatment facilities (PRTFs) are non-hospital facilities offering intensive inpatient services to individuals under the age of 21 who have various behavioral health issues. PRTFs are required to ensure that all medical, psychological, social, behavioral and developmental aspects of the member's situation are assessed and that treatment for those needs are reflected in the plan of care (POC) per 42 CFR §441.155. In addition to services provided by and in the facility, when they can be reasonably anticipated on the active treatment plan, the PRTF must ensure that the member receives all treatment identified on the active treatment plan and any other medically necessary care required for all medical, psychological, social, behavioral and developmental aspects of the member's situation.

Assessment and Treatment Planning

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

The POC must:

1. Be based on a diagnostic evaluation conducted within the first 24 hours of admission in consultation with the youth and the parents/legal guardian that includes examination of the medical, psychological, social, behavioral and developmental aspects of the member's situation and reflects the need for inpatient psychiatric care;
2. Be developed by a team of professionals specified under §441.156 in consultation with the child and the parents, legal guardians or others in whose care the youth will be released after discharge;
3. State treatment objectives;
4. Prescribe an integrated program of therapies, activities and experiences designed to meet the objectives; and

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5. Include, at an appropriate time, post-discharge plans and coordination of inpatient services, with partial discharge plans and related community services to ensure continuity of care with the member's family, school and community upon discharge.

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

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

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

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

Eligibility Criteria

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

1. Ambulatory care resources available in the community do not meet the treatment needs of the member;
2. Proper treatment of the member's psychiatric condition requires services on an inpatient basis under the direction of a physician; and

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3. The services can be reasonably expected to improve the member's condition or prevent further regression, so that the services will no longer be needed.

The independent team pre-certifying the PRTF stay must:

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

Allowed Mode(s) of Delivery

1. On-site.

Provider Responsibilities

Children/adolescents receiving services in a PRTF program must have access to education services, including supports to attend public school if possible, or in-house educational components, or vocational components if serving adolescents.

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

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

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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). PRTFs must have all research-based programming incorporated into the program description and approved by their contracted managed care organizations (MCOs) as part of the credentialing and re-credentialing process or whenever changes are made, subject to OBH review.

Provider Qualifications

The facility must provide treatment meeting State regulations per LAC 48: I. Chapter 90.

Agency

Agencies that operate as PRTFs must:

1. Be licensed by the Louisiana Department of Health (LDH) in accordance with Louisiana Administrative Code (LAC) 48:I.Chapter 90 and accredited prior to enrollment by an LDH approved accrediting body: Commission on Accreditation of Rehabilitation Facilities (CARF), Council on Accreditation (COA) or The Joint Commission (TJC). Denial, loss of, or any negative change in accreditation status must be reported to their contracted managed care organizations (MCOs) in writing immediately upon notification by the accreditation body. The PRTF must be accredited prior to delivering services;
2. Arrange for and maintain 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:
 - a. The Psychiatric Residential Treatment Facilities licensing regulations established by LAC 48:I.Chapter 90, which includes those for owners, managers, and administrators, any applicant for employment, contractor, volunteer and other person who will provide services to the residents prior to that person working at the facility;

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- b. La. R.S. 40:1203.1 et seq. associated with criminal background checks of un-licensed workers providing patient care;
 - c. La. R.S. 15:587, as applicable; and
 - d. Any other applicable state or federal law.
3. 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;
4. 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;
5. 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>);
6. Arrange for and maintain documentation that all persons, prior to employment, are free from tuberculosis (TB) in a communicable state via skin testing (or chest exam

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if recommended by physician) to reduce the risk of such infections in members and staff. Results from testing performed over 30 days prior to date of employment will not be accepted as meeting this requirement;

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

Emergency Preparedness Regulations

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

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

1. **Risk assessment and emergency planning** - CMS requires facilities to perform a risk assessment that uses an “all-hazards” approach prior to establishing an emergency plan;
2. **Communication plan** - CMS requires facilities to develop and maintain an emergency preparedness communication plan that complies with both federal and state laws. Patient care must be well coordinated within the facility, across healthcare providers, and with state and local public health departments and emergency management agencies and systems to protect patient health and safety in the event of a disaster;

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3. **Policies and procedures** - CMS requires that facilities develop and implement policies and procedures that comply with federal and state law, and that support the successful execution of the emergency plan and risks identified during the risk assessment process; and
4. **Training and testing** - CMS requires that facilities develop and maintain an emergency preparedness training and testing program that complies with federal and state law, and that is updated at least annually.

The PRTF shall also meet the state requirements of LAC 48:1 Chapter 90 §9083. Safety and Emergency Preparedness.

Staff

Staffing for the facility must be consistent with State licensure regulations.

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

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

1. Pass criminal background check through the Louisiana DPS, State Police prior to employment;
2. 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;
3. Direct care staff must not have a finding on the Louisiana State Adverse Action List;
4. Pass a TB test prior to employment;
5. Pass drug screening tests as required by agency's policies and procedures;

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6. Complete American Heart Association (AHA) recognized First Aid and CPR and training. Psychiatrists, advanced practical registered nurses (APRNs/physician assistants (PAs), registered nurses (RNs) and licensed practical nurses (LPNs) are exempt from this training. (See Appendix D of this manual chapter); and
7. Complete all required training appropriate to the approved program description.

Team Qualifications

Per federal regulations at 42 CFR §441.156 and state regulations at LAC 48: I. Chapter 90. §9067, the team must include, at a minimum, either:

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

The team must also include one of the following:

1. A licensed clinical social worker (LCSW);
2. A RN with specialized training or one year's experience in treating individuals with mental illness;
3. An occupational therapist who is licensed and who has specialized training or one year of experience in treating individuals with mental illness; or
4. A licensed psychologist or medical psychologist.

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

Allowed Provider Types and Specialties

1. PT 96 Psychiatric Residential Treatment Facility, PS 9B Psychiatric Residential Treatment Facility;
2. PT 96 Psychiatric Residential Treatment Facility, PS 8U Substance Use or Addiction; and
3. PT 96 Psychiatric Residential Treatment Facility, PS 8R Other Specialization.

Limitations/Exclusions

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

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

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

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Reimbursement

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

Reimbursement for PRTF is based on the following criteria:

1. Each PRTF provider must enter into a contract with one or more managed care organization in order to receive reimbursement for Medicaid services;
2. LDH or its fiscal intermediary must make monthly capitation payments to the MCOs, and the MCOs will determine the rates paid to its contracted providers. Payment must be no less than the minimum Medicaid rate; and
3. Covered inpatient PRTF activities for individuals under twenty-one (21) years of age must be reimbursed by Medicaid.

Free-standing PRTFs

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

1. Occupational therapy/physical therapy/speech therapy;
2. Laboratory; and
3. Transportation.

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

In-State PRTF Reimbursement Rates

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

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

Out-of-State PRTF Reimbursement Rates

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

Cost Reports

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

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

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

Level 3.7 Medically Monitored High Intensity Inpatient Treatment – Adolescent

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

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1. Psychiatric and substance use assessments;
2. Diagnosis treatment; and
3. Habilitative and rehabilitation services.

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

All facilities are licensed by LDH in accordance with LAC 48:I.Chapter 90 and must be accredited prior to enrollment by an LDH approved national accrediting body: CARF, COA or TJC. Denial, loss of, or any negative change in accreditation status must be reported to their contracted MCOs in writing immediately upon notification by the accreditation body.

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

Admission Guidelines

Individuals in this level of care may have co-occurring addiction and mental health disorders that meet the eligibility criteria for placement in a co-occurring-capable program or difficulties with mood, behavior or cognition related to a substance use or mental disorder, or emotional behavioral

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or cognitive symptoms that are troublesome, but do not meet the DSM criteria for mental disorder. Admission guidelines for PRTF services are:

1. Acute intoxication and/or withdrawal potential – None or minimal/stable withdrawal risk;
2. Biomedical conditions and complications – Moderate to severe conditions (which require 24-hour nursing and medical monitoring or active treatment but not the full resource of an acute care hospital);
3. Emotional, behavioral or cognitive conditions and complications – Moderate to severe conditions and complications. These symptoms may not be severe enough to meet diagnostic criteria but interfere or distract from recovery efforts (for example, anxiety/hypomanic or depression and/or cognitive symptoms, which may include compulsive behaviors, suicidal or homicidal ideation, with a recent history of attempts but no specific plan, or hallucinations and delusions without acute risk to self or others) are interfering with abstinence, recovery and stability to such a degree that the individual needs a structured 24-hour, medically monitored (but not medically managed) environment to address recovery efforts;
4. Readiness to change – Member is in need of intensive motivating strategies, activities and processes available only in a 24-hour structured medically monitored setting (but not medically managed);
5. Relapse, continued use or continued problem potential – Member is experiencing an escalation of relapse behaviors and/or acute psychiatric crisis and/or reemergence of acute symptoms and is in need of 24-hour monitoring and structured support; and
6. Recovery environment – Environment or current living arrangement is characterized by a high risk of initiation or repetition of physical, sexual or emotional abuse or substance use so endemic that the patient is assessed as unable to achieve or maintain recovery at a less intensive level or care.

Screening/Assessment/Treatment Plan Review

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

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

1. Medical;
2. Psychological;
3. Alcohol; and
4. Drug.

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

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

Provider Qualifications

Agency

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

1. Licensed as a PRTF by LDH per LAC 48: I. Chapter 90;
2. Physician directed and meet the requirements of 42 CFR §441.151, including requirements referenced therein to 42 CFR 483 subpart G;
3. Arrange for and maintain 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:

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- a. The Psychiatric Residential Treatment Facilities licensing regulations established by the Louisiana Administrative Code (LAC) 48:I.Chapter 90, which includes those for owners, managers, and administrators any applicant for employment, contractor, volunteer and other person who will provide services to the residents prior to that person working at the facility;
 - b. La. R.S. 40:1203.1 et seq. associated with criminal background checks of un-licensed workers providing patient care;
 - c. La. R.S. 15:587, as applicable; and
 - d. Any other applicable state or federal law.
4. 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;
5. 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;

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6. Providers are required to maintain results in personnel records that checks have been completed. The OIG maintains the LEIE on the OIG website (<http://exclusions.oig.hhs.gov>) and the LDH Adverse Action website is located at <https://adverseactions.ldh.la.gov>;
7. Arrange for and maintain documentation that all persons, prior to employment, are free from Tuberculosis (TB) in a communicable state via skin testing (or chest exam if recommended by physician) to reduce the risk of such infections in members and staff. Results from testing performed over 30 days prior to date of employment will not be accepted as meeting this requirement;
8. Establish and maintain written policies and procedures inclusive of drug testing staff to ensure an alcohol and drug-free workplace and a workforce free of substance use (See Appendix D);
9. Maintain documentation that all direct care staff, who are required to complete First Aid and cardiopulmonary resuscitation (CPR) training, complete American Heart Association (AHA) recognized training within 90 days of hire, which must be renewed within a time period recommended by the AHA. (See Appendix D); and
10. Maintain documentation of verification of staff meeting educational and professional requirements, licensure (where applicable), as well as completion of required trainings for all staff.

Emergency Preparedness Regulations

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

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

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

The PRTF shall also meet the state requirements of LAC 48:1 Chapter 90 §9083 Safety and Emergency Preparedness.

Staff

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

Staff who provide services in a PRTF setting must:

1. Pass criminal background check through the Louisiana Department of Public Safety, State Police prior to employment;
2. 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;

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3. Direct care staff must not have a finding on the Louisiana State Adverse Action List;
4. Pass a TB test prior to employment;
5. Pass drug screening tests as required by agency’s policies and procedures;
6. Complete American Heart Association (AHA) recognized First Aid and CPR training. Psychiatrists, APRNs/PAs, RNs and LPNs are exempt from this training (See Appendix D); and
7. Complete all required training appropriate to the approved program description.

Staffing Requirements

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

The provider must ensure that:

1. There is a licensed physician, medical director – licensed physician(s) on site as needed for management of psychiatric/medical needs. 24 hour on-call availability;
2. There is a licensed psychologist available as needed;
3. There is licensed nursing staff present – One FTE Supervisor (APRN/NP/RN), 24 hour on-call availability;
4. There is one FTE RN/LPN available on duty on site at all times;
5. There is a licensed or certified clinician or counselor with direct supervision by an LMHP, or unlicensed professional (UP) under supervision of a clinical supervisor; Caseloads not to exceed eight members;
6. The clinical supervisor is available for clinical supervision when needed and by telephone for consultation;

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7. An LMHP is available on site 40 hours per week;
8. The facility shall maintain, in accordance with LAC 48:1 Chapter 90:
 - a. 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.); and
 - b. 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.).
9. There is clerical support staff available – 1 to 2 FTE per day shift;
10. There is an activity/occupational therapist – one FTE;
11. There is a care coordinator – one FTE per day shift, and/or duties may be assumed by clinical staff;
12. A peer specialist is recommended;
13. Physicians, who are available 24 hours a day by telephone. (A PA may perform duties within the scope of their practice as designated by physician). An APRN may perform duties within the scope of their practice;
14. Licensed, certified or registered clinicians provide a planned regimen of 24-hour, professionally directed evaluation, care and treatment services for members and their families; and
15. An interdisciplinary team of appropriately trained clinicians, such as physicians, nurses, counselors, social workers and psychologists, is available to assess and treat the individual and to obtain and interpret information regarding the member's needs. The number and disciplines of team members are appropriate to the range and severity of the individual's problems.

Allowed Provider Types and Specialties

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

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Federally Qualified Health Centers (FQHCs) must be certified by the federal government. Rural health centers (RHCs) must be licensed by the Louisiana Department of Health (LDH) Health Standards Section (HSS) pursuant to R.S. 40:2197.

Licensed mental health professionals (LMHPs) and staff of FQHCs offering behavioral health services in an FQHC are required to meet qualifications specified for other licensed practitioners and direct care staff in this Manual.

FQHCs/RHCs, and practitioners, should routinely review and follow the governing authorities (i.e. Administrative Rules, Medicaid State Plan and appropriate Provider Manual Chapters) and other Department issued guides and specifications for FQHCs/RHCs to determine which approved practitioners may provide behavioral health services.

The FQHC Provider Manual and RHC Provider Manual can be accessed through the following link: http://www.lamedicaid.com/provweb1/Providermanuals/Intro_Page.aspx.

FQHCs/RHCs must comply with federal emergency preparedness regulations associated with 42 CFR §491.12 in order to participate in the Medicaid [or Medicare] program. Regulations must be implemented by November 15, 2017. They include safeguarding human resources, maintaining business continuity and protecting physical resources.

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

1. **Risk Assessment and Emergency Planning** – The U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) requires facilities to perform a risk assessment that uses an “all-hazards” approach prior to establishing an emergency plan;
2. **Communication Plan** – CMS requires facilities to develop and maintain an emergency preparedness communication plan that complies with both federal and state laws. Patient care must be well coordinated within the facility, across healthcare providers, and with state and local public health departments and emergency management agencies and systems to protect patient health and safety in the event of a disaster;

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3. **Policies and Procedures** – CMS requires that facilities develop and implement policies and procedures that comply with federal and state law, and that support the successful execution of the emergency plan and risks identified during the risk assessment process; and
4. **Training and Testing** – CMS requires that facilities develop and maintain an emergency preparedness training and testing program that complies with federal and state law, and that is updated at least annually.

The CMS Emergency Preparedness Regulation Guidance and Resources can be accessed through the following link: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html>

Allowed Provider Types and Specialties

1. PT 72 FQHC, PS 42, PSS 8E;
2. PT 79 RHC, PS 94, PSS 8E; and
3. PT 87 RHC, PS 94, PSS 8E.

Eligibility Criteria

All Medicaid-eligible adults and children who meet medical necessity criteria.

Allowed Mode(s) of Delivery

1. Individual;
2. Family;
3. Group;
4. On-site;
5. Off-site; and
6. Tele-video.

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CRISIS RESPONSE SERVICES

Crisis response services are provided to form a continuum of care offering relief, resolution, and intervention through crisis supports and services to decrease the unnecessary use of emergency departments and inpatient hospitalizations for members whose needs are better met in the community. These services are available 24 hours a day, seven days a week. Care coordination is a key element across all of these services, coordinating across the services and beyond depending on the needs of the member. Providers delivering these services will respond to crises by initiating the least restrictive response commensurate with the risk. This level of care involves supporting and collaborating with the member to achieve symptom reduction by delivering brief, resolution-focused treatment, problem solving and developing useful safety plans that will assist with community tenure. These services are intended for members with urgent mental health distress only.

Crisis response services are not intended for, and shall not replace existing behavioral health services. Rather, crisis response services shall be used for new or unforeseen crises not otherwise addressed in the member’s existing crisis plan. Unless directly referred to Community Brief Crisis Support (CBCS) by the managed care organization (MCO)/managed care entity (MCE), these services are not to be utilized as step down services from residential or inpatient psychiatric or Substance Use Disorder (SUD) treatment service settings.

Crisis response services are not intended to substitute for already-approved and accessible Community Psychiatric Support and Treatment (CPST), Psychosocial Rehabilitation (PSR), or Assertive Community Treatment (ACT) services with a member’s already-established provider.

For individuals under the age of 21, crisis services additionally are not intended to substitute for already-approved and accessible home and community based interventions as included on the plan of care (POC) for individuals enrolled in the Coordinated System of Care (CSoc) program.

NOTE: The crisis response services outlined here are provided outside of the mental health rehabilitation (MHR) crisis intervention services as defined in the Section 2.3 Outpatient Services – Mental Health Rehabilitation. MHR crisis intervention services are intended for use by the members accessing CPST and PSR services. MHR providers are required to have crisis mitigation plans, which shall not include use of or referral to these crisis response services.

The provisions contained in this section apply to the following crisis response services:

1. Mobile Crisis Response (MCR) (Effective 3/1/2022) (expansion to ages under 21 effective 04/01/2024);

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2. Behavioral Health Crisis Care (BHCC) (Effective 4/1/2022) for ages 21 and above; and
3. CBCS (Effective 3/1/2022) (expansion to ages under 21 effective 04/01/2024).

Common Components

Preliminary Screening

1. A brief preliminary, person-centered screening of risk, mental status, medical stability and the need for further evaluation or other mental health services shall be conducted. This screening and shall include contact with the member, family members or other collateral sources with pertinent information for the purpose of the screening and/or referral to and coordination with other alternative behavioral health services at an appropriate level; and
2. When a member is referred from another crisis provider, the screening of risk, mental status and medical stability and the need for further evaluation or other mental health services builds on the screening and assessments conducted by the previous crisis service providers.

Assessments

1. If further evaluation is needed, an assessment must be conducted by a licensed mental health professional (LMHP) or psychiatrist, unless otherwise specified in the MCR staff requirements section, with experience regarding this specialized mental health service. This evaluation shall include contact with the member, family members, or other collateral sources with pertinent information for the purpose of the assessment and/or referral to and coordination with other alternative behavioral health services at an appropriate level. If the member expressly refuses to include family or other collaterals sources, it must be documented in the member record; and
2. When a member is referred from another crisis provider, if further evaluation is needed, the assessment builds on the screening or assessments conducted by the previous crisis service providers.

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Interventions

1. Interventions are driven by the member and include resolution-focused treatment, peer support, safety planning, service planning, and care coordination designed to de-escalate the crisis. Strategies are developed for the member to use post current crisis to mitigate risk of future incidents until the member (and caregiver, for youth-directed services) engages in alternative services, if appropriate. Interventions must be provided under the supervision of an LMHP or psychiatrist, unless otherwise stated, who is acting within the scope of their professional license and applicable state law:
 - a. When a member is referred from another crisis provider to CBCS, the intervention is driven by the member and is developed by a qualified licensed professional (as defined in the MCR staff requirements section) or non-licensed staff in collaboration with a qualified licensed professional building on and updating the strategies developed by the MCR or BHCC providers; and
 - b. For services delivered to minors under the age of 18, the interventions focus on the crisis experience of the minor and the experience of the person with parental authority whose minor is in crisis. Crisis services staff, with particular assistance from the recognized family peer support specialist (RFPSS), provide support to caregivers during interventions for their children. RFPSS team members work collaboratively with other crisis services team members to intervene and stabilize minor in crisis, with a focus on providing support to caregivers, helping caregivers actively engage in the crisis services intervention, and offering their own personal experience to help educate the next steps for the minor in crisis.
2. Short-term goals are set to ensure stabilization, symptom reduction and restoration to a previous level of functioning. The intervention shall be developed with input from the member, family and other collateral sources;
3. Interventions include using person-centered approaches, such as crisis resolution and debriefing with the member (and caregiver, when present for minor-directed services) experiencing the crisis for relief, resolution and problem solving of the crisis;

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4. Substance use shall be recognized and addressed in an integrated fashion, as it may add to the risk, increasing the need for engagement in care; and
5. Support, education, and consultation is provided to the member, family, and collateral supports.

Care Coordination

1. All levels of crisis providers shall coordinate care for the member following the crisis event as needed. Care coordination includes the following activities:
 - a. Coordinating the transfer to alternate levels of care within 24 hours when warranted, including but not limited to:
 - i. **Primary medical care** - Member requires primary medical care with an existing provider;
 - ii. **Community based behavioral health provider** - Member requires ongoing support at a lower level of care with the member's existing behavioral health provider. The member shall return to existing services as soon as indicated and accessible;
 - iii. **Behavioral Health Crisis Care (BHCC) Center for adults** - Member requires ongoing support and time outside of the home;
 - iv. **Community Brief Crisis Support (CBCS)** - Member requires ongoing support at home or in the community subsequent to an initial crisis;
 - v. **Crisis Stabilization (CS)** – Member may need additional time outside of the home without being at immediate risk for inpatient treatment due to experiencing severe intoxication or withdrawal episodes that cannot be managed safely in this setting, immediate suicide risk, or currently violent;
 - vi. **Inpatient treatment** – Member is in medical crisis, experiencing severe intoxication or withdrawal episodes, actively suicidal, homicidal, gravely disabled, or currently violent; and

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- vii. **Residential substance use treatment** - Member requires ongoing support and treatment outside of the home for a SUD.

NOTE: Crisis care shall continue until the crisis is resolved, the member has met with the accepting behavioral health treatment provider of ongoing care, or until the member no longer needs crisis services.

- b. Coordinating contact through a warm handoff with the member’s MCE to link the member with no current behavioral health provider and/or primary medical care provider to outpatient services as indicated;
- c. Coordinating contact through a warm handoff with the member’s existing or new behavioral health provider. For individuals under the age of 21, this may include a warm handoff with the member’s wraparound agency if the individual is enrolled or has been referred to CSoC; and
- d. Providing any member records to the existing or new behavioral health provider or another crisis service to assist with continuing care upon referral.

Service Delivery

There shall be member involvement throughout the planning and delivery of services. Services shall be:

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

Soft Launch

During initial implementation of youth MCR and CBCS, the Louisiana Department of Health (LDH) is allowing time for the providers to reach full capacity with regards to hiring RFPSS.

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Provider Responsibilities

Listed below are the responsibilities of providers:

1. All services shall be delivered in accordance with federal and state laws and regulations, the *Medicaid Services Manual* and other notices or directives issued by LDH. The provider shall create and maintain documents to substantiate that all requirements are met. (See Section 2.6 Record Keeping);
2. Provider must ensure that 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; and
3. Any licensed practitioner providing mental health services must operate within the scope of practice of their license.

Supervision of Non-Licensed Staff

Provisionally Licensed Professional Counselors (PLPCs), Provisionally Licensed Marriage and Family Therapists (PLMFTs) or Licensed Master Social Workers (LMSWs) delivering MCR services must be under regularly scheduled supervision in accordance with requirements established by the practitioner's professional licensing board. Proof of the board approved supervision must be held by the crisis response provider employing these staff.

Services provided by non-licensed staff must be provided under the 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 an individual meeting the qualifications of an LMHP (excluding Licensed Addiction Counselors (LACs)) or a psychiatrist. LMHP or psychiatrist supervisors must have the practice-specific education, experience, training, credentials, and licensure to coordinate an array of mental and/or behavioral health services. Providers may have more than one LMHP or psychiatrist supervisor providing required clinical supervision to non-licensed staff.

1. Supervision refers to clinical support, guidance and consultation afforded to non-licensed staff rendering crisis response services, and shall not be replaced by licensure supervision of master's level individuals pursuing licensure;
2. Staff shall receive a minimum of **four** hours of clinical supervision per month for full-time staff and a minimum of **one** hour of clinical supervision per month for

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part-time staff, which shall consist of **no less than one hour of individual supervision**. Each month, the remaining hours of supervision may be in a group setting. Given consideration of case load and acuity, additional supervision may be indicated;

3. The LMHP (excluding LACs) or psychiatrist supervisor must ensure services are in compliance with the established requirements of this service;
4. Group supervision means one LMHP or psychiatrist supervisor (excluding LACs) and not more than six supervisees in a supervision session;
5. A maximum of 75 percent of the individual and group supervision 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;
6. Supervision with the LMHP or psychiatrist must:
 - a. For MCR and CBCS, occur before initial services for member begin;
 - b. Have intervention notes discussed in supervision must have the LMHP or psychiatrist supervisor's signature; and
 - c. Have documentation reflecting the content of the training and/or clinical guidance. The documentation must include the following:
 - i. Date and duration of supervision;
 - ii. Identification of supervision type as either individual or group supervision;
 - iii. Name and licensure credentials of the LMHP supervisor;
 - iv. Name and credentials (provisionally licensed, master's degree, bachelor's degree, or high school degree) of the supervisees;
 - v. Focus of the session and subsequent actions that the supervisee must take;
 - vi. Date and signature of the LMHP or psychiatrist supervisor;
 - vii. Date and signature of the supervisees; and
 - viii. Start and end time of each supervision session.

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7. Supervision must be provided in a culturally sensitive manner that represents the cultural needs and characteristics of the staff, the service area, and the population being served; and
8. Supervision of RPSSs and RFPSSs must be provided by an LMHP or psychiatrist who has successfully completed an Office of Behavioral Health (OBH) approved peer specialist supervisor training. Supervisors shall complete the peer specialist supervisor training within six months of hire.

Documentation

All crisis providers shall maintain case records that include, at a minimum:

1. Name of the member, and if the member is a minor under the age of 18, name of the parent or person with legal authority to act on the minor’s behalf;
2. Dates, and time of service;
3. Place of services, for MCR and CBCS services;
4. Preliminary screening;
5. Assessments (if necessary);
6. Intervention notes;
7. Documentation of coordination attempts;
8. Discharge summary; and
9. Consent for treatment, including:
 - a. **Implied consent during an emergency**
When an emergency exists, consent to treatment for a member of any age is implied. An emergency is defined as a situation wherein: (1) the treatment is medically necessary; and (2) a person authorized to consent is not readily available; and (3) any delay in treatment could reasonably be expected to jeopardize the life or health of the person affected or could reasonably result in disfigurement or impair faculties. The provider’s case record must

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document all circumstances regarding the emergency care and the patient's implied consent, including all attempts to obtain consent for treatment; and

b. **Consent needed for non-emergencies**

Providers must obtain oral or written consent, when an emergency does not exist or no longer exists. Written consent to treatment is preferred. For treatment of a minor (under the age 18 during a non-emergency, documentation of consent for treatment shall include consent from the minor, parent, or person with legal authority to act on the minor's behalf.

The preliminary screening shall include, at a minimum, the reason for presentation, nature of the crisis, chief complaint, medical stability, grave disability and risks of suicidality, of self-harm, and of danger to others. If further evaluation is needed, an assessment must be conducted by an LMHP or psychiatrist, unless otherwise specified in the MCR staff requirements section, with experience regarding this specialized mental health service. The assessment shall include a mental status exam and a current behavioral health history including the current behavioral health provider.

Notes on the interventions delivered shall be written after every encounter. All follow-up encounters and attempts shall be documented. The member's record must reflect relief, resolution and problem solving of the identified crisis or referral to an alternate provider.

Attempts to communicate with treating providers and family, when possible, shall be documented.

The discharge summary shall include communications with treating providers and family when possible. A brief crisis plan/strategies are developed for the member to use post current crisis to mitigate the risk of future incidents until the member engages in alternative services, if appropriate.

Reporting Requirements

Crisis response providers shall comply with data collection and reporting requirements as specified by LDH.

Provider Qualifications**Agency/Facility**

To provide crisis response services, providers must meet the following requirements:

1. Licensure pursuant to La. R.S. 40:2151, et. seq. or La. R.S. 40:2180.12, et. seq.;

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NOTE: Providers that meet the provisions of La. R.S. 40:2151: Providers that meet the provisions of La. R.S. 40:2154, et.seq. shall be licensed by LDH Health Standards as a Behavioral Health Service provider (BHSP) crisis intervention program in order to participate in the Louisiana Medicaid program and receive Medicaid payments. MCR providers shall be licensed by LDH Health Standards as a BHSP crisis intervention-mobile crisis response program in order to operate as a MCR provider, participate in the Louisiana Medicaid program and receive Medicaid payments. Existing licensed BHSP crisis intervention programs shall be required to obtain the appropriate license prior to providing MCR services.

2. Accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or The Joint Commission (TJC). Denial, loss of, or any negative change in accreditation status must be reported in writing immediately upon notification to the managed care entities with which the provider contracts or is being reimbursed;

NOTE: Providers must apply for accreditation and pay accreditation fees prior to being contracted and reimbursed by a managed care entity, and must maintain proof of accreditation application and fee payment. Providers must attain full accreditation within 18 months of the initial accreditation application date.

3. Services must be provided under the supervision of a LMHP or a physician who is acting within the scope of their professional license and applicable state law. The term “supervision” refers to clinical support, guidance and consultation afforded to non-licensed staff, and shall not be confused with 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;
4. Arrange for and maintain documentation that individuals pass criminal background checks, including sexual offender registry checks prior to employment (or contracting, volunteering, or as required by law), in accordance with all of the below:
 - a. BHSP licensing regulations established by the Louisiana Administrative Code 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; or
 - b. Level III Crisis Receiving Centers (CRC) licensing regulations established by the Louisiana Administrative Code 48:I. Chapter 53, which includes

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- those for owners, managers, and administrators; for any individual treating children and/or adolescents; and for any non-licensed direct care staff;
- c. La. R.S. 40:1203.1 *et seq.* associated with criminal background checks of un-licensed workers providing patient care;
 - d. La. R.S. 15:587, as applicable; and
 - e. Any other applicable state or federal law.
5. Provider 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;
6. 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 who performs services that are compensated with Medicaid/Medicare funds, including but not limited to licensed and non-licensed staff, interns and contractors:
- a. Once employed, check the list 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 employee or contractor has been excluded from participation in the Medicaid or Medicare program by Louisiana Medicaid or the OIG; and
 - b. 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 the OIG.

NOTE: Providers are required to maintain results in personnel records that these 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>;

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12. Arrange for and maintain documentation that all persons, prior to employment, are free from Tuberculosis (TB) in a communicable state as defined by the Louisiana Administrative Code 51:II.Chapter 5 to reduce the risk of such infections in members and staff. Results from testing performed over 30 days prior to date of employment will not be accepted as meeting this requirement;
13. Establish and maintain written policies and procedures inclusive of drug testing staff to ensure an alcohol and drug-free workplace and a workforce free of substance use (See Appendix D Curriculum/Equivalency Standards);
14. Maintain documentation that all direct care staff, who are required to complete first aid, cardiopulmonary resuscitation (CPR) and seizure assessment training, complete American Heart Association (AHA) recognized training within 90 days of hire, which shall be renewed within a time period recommended by the AHA (See Appendix D Curriculum/Equivalency Standards);
15. Maintain documentation of verification of completion of required trainings for all staff;
16. Ensure and maintain documentation that all persons employed by the organization complete training in the OBH approved crisis response curriculum. (See Appendix D Curriculum/Equivalency Standards); and
17. **Providers that meet one of applicability exemptions of La. R.S. 40:2154:** For a provider that meets one of applicable exemptions of the BHSP licensing statute, La. R.S. 40:2154, the provider is required to obtain a BHSP license or CRC Level III license issued by LDH Health Standards. If such provider does not have a BHSP license or CRC Level III license issued by LDH Health Standards, the provider may no longer participate in the Louisiana Medicaid program or receive Medicaid payments for crisis services.

Staff

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

Staff must also meet the following requirements:

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1. Be at least 24 years old;
2. Unlicensed staff must have a minimum of bachelor’s degree (preferred) **or** an associate’s degree and two years of work experience in the human services field **or** meet qualifications as either an RPSS or an RFPSS:
 - a. For RPSS qualifications, see the Section 2.3 – Outpatient Services - Peer Support Services, as well as Appendix D for Peer and Family Support Specialists Approved Curriculum for detailed training and continuing education requirements; and
 - b. For RFPSS qualifications, see Appendix D for Peer and Family Peer Support Specialists Approved Curriculum for detailed training and continuing education requirements.
3. Satisfactory completion of criminal background check pursuant to the BHSP licensing regulations (the Louisiana Administrative Code 48:I.Chapter 56), the Louisiana Administrative Code 48:I.Chapter 53, 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. 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;
 - b. Direct care staff must not have a finding on the Louisiana State Adverse Action List; and
 - c. Comply with Direct Service Worker Registry law established by La. R.S. 40:2179 *et seq.*, and meet any additional qualifications established under Rule promulgated by LDH in association with this statute.
4. Pass a Tuberculosis (TB) test prior to employment in accordance with the Louisiana Administrative Code 51:II.Chapter 5; OR be free from TB in a communicable state as defined by the Louisiana Administrative Code 51:II.Chapter 5;
5. Pass drug screening tests as required by the provider’s policies and procedures;
6. Complete American Heart Association (AHA) recognized First Aid, CPR and seizure assessment training. Psychiatrists, advanced practice registered nurses (APRNs, clinical nurse specialists (CNSs), physician assistants (PAs), registered

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nurses (RNs) and licensed practical nurses (LPNs) are exempt from this training (see Appendix D);

7. Non-licensed direct care staff are required to complete a basic clinical competency training program approved by OBH prior to providing the service (see Appendix D); and
8. Complete training curriculum approved by OBH prior to providing the service (see Appendix D).

In addition to requirements for all crisis response services staff, the RFPSS must also meet the following qualifications:

1. Must have lived experience as the caregiver for a child with complex needs inclusive of social, emotional, mental health, and/or substance use concerns, and/or involvement with child welfare or juvenile justice systems;
2. Must have a high school diploma or GED;
3. Must be recognized as a peer specialist by an OBH-approved organization; and
4. Must sign acknowledgement and receipt of Peer Support Specialist Code of Ethics.

The RPSS 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). (See the Peer Support Services chapter of the Louisiana Medicaid Behavioral Health Provider manual).

Mobile Crisis Response (MCR) (Effective 3/1/2022) (expansion to ages under 21 effective 04/01/2024)

MCR services are an initial or emergent crisis response intended to provide relief, resolution and intervention through crisis supports and services during the first phase of a crisis in the community. MCR is a face-to-face, time-limited service provided to a member who is experiencing a psychiatric crisis due to mental health or substance use until the member experiences sufficient relief/resolution and the member can remain in the community and return to existing services or be linked to alternative behavioral health services which may include higher levels of treatment like inpatient psychiatric hospitalization.

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MCR providers are dispatched after an initial triage screening determines that MCR is the most appropriate service. MCR services are available 24 hours a day, seven days a week and must include maximum one hour urban and two hour rural face-to-face/onsite response times.

Components

1. Provide services (screening, assessment, interventions, and care coordination) as outlined in the general section; and
2. Provide follow up to the member and authorized member’s caretaker and/or family within 24 hours as appropriate and desired by the member and up to 72 hours to ensure continued stability post crisis for those not accessing higher levels of care or another crisis service, including but not limited to:
 - a. Telephonic or face to face follow-up based on a clinical individualized need, with face to face follow-up highly preferred for service delivery to individuals under the age of 21; and
 - b. Additional calls/visits to the member following the initial crisis response as indicated in order to stabilize the individual in the aftermath of the crisis. If the member indicates no further communication is desired, it must be documented in the member’s record.

Eligibility Criteria

The medical necessity for these rehabilitative services must be determined by and recommended by an LMHP or physician to promote the maximum reduction of symptoms and/or restoration of a member aged 21 years and over to their best age-appropriate functional level. Members in crisis who require this service may be using substances during the crisis, and substance use will not, in and of itself, disqualify them for eligibility for the service.

All members who self-identify as experiencing a seriously acute psychological/emotional change, that results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved to effectively resolve it, are eligible for initial/emergent crisis services as long as medical necessity is met.

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For minors under the age of 18, eligibility for initial/emergent crisis services based on “self-identification” that the member is experiencing a crisis includes self-identification by the minor and identification by the current physical caregiver to the minor, under the principle that “the crisis is defined by the caller.” The caller, who identifies the crisis and initiates MCR services for minor, may commonly be an adult currently serving in a caregiving role to the minor in the setting where the crisis is being experienced. This may include, but is not limited to:

1. Caregivers in a home setting, including a parent, person with legal authority to act on the minor’s behalf, foster parent, fictive kin, or other family member serving in a caregiving role in the home or community setting at the time that the minor is experiencing the crisis;
2. Teacher or staff in a school setting where the minor is experiencing a crisis;
3. Care staff at a group home setting where the minor currently resides and where the minor is experiencing the crisis; or
4. Helping professional accompanying the minor at the time of the crisis, such as a pediatrician, FINS worker, or probation officer.

A child experiencing a sudden change in their living situation, such as removal from a family or foster family home and move to a new family or foster family home, may experience this as a crisis that exceeds the abilities and the resources of those involved to effectively resolve it. A minor or their caregiver self-identifying this experience as a crisis is eligible for MCR services.

Consent to MCR services for minors less than 18 years old

When the call is initiated by a caller who is not a parent with parental authority or otherwise a person with legal authority to act on behalf of the minor, the caller must attempt to contact the parent, or person with legal authority, to obtain their consent for the minor in crisis to receive MCR services, during the time when the MCR team is dispatching. (For example, school staff do not have parental authority; therefore school staff must call the person with parental authority during the time when the MCR team is dispatching and attempt to gain their consent). If the parent or person with legal authority, is not readily available, continuous efforts must be made by the caller and the MCR team to reach the parent, or person with legal authority, throughout the minor’s intervention, to inform them of the situation and to attempt to obtain their consent for treatment.

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While an un-emancipated minor usually needs the consent of a parent or person with legal authority to act on behalf of the minor, before receiving medical care, including behavioral health care, a minor may receive emergency medical treatment to preserve life and prevent serious impairment without consent from a parent or person with legal authority to act on the minor’s behalf.

An emergency is defined as a situation wherein:

1. Treatment is medically necessary;
2. Person authorized to consent is not readily available; and
3. Any delay in treatment could reasonably be expected to jeopardize the life or health of the minor or could reasonably result in disfigurement or impair faculties.

In these emergency situations, services can and should be provided to the minor, even if attempts to obtain consent from the person with parental authority were unsuccessful, while continued attempts are made to contact the person with parental authority in order to obtain their consent for the services. In the event the parent, or person with legal authority, objects or refuses to consent to the MCR services for the minor, the intervention must cease once all immediate threats to the child’s life are resolved. *See Louisiana Children’s Code article 1554*, which provides that while parents have the right to refuse care for minors, they generally cannot do so if it endangers the child’s life.

NOTE: A minor in crisis may consent to the MCR services if they believe they are afflicted with an illness or disease and possess the physical and mental capacity to consent to care. La. R.S. 40:1079.1(A). Unless otherwise stated by available legal documentation, an individual who is aged 18 years or older can individually consent to MCR services and does not need parental consent. Additionally, a person 18 years of age or older may refuse to consent to medical or surgical treatment as to their own person.

Service Utilization

MCR is an initial crisis response and is allowed without the requirement of a prior authorization in order to address the emergent issues in a timely manner, although providers are required to notify the MCE when its member presents. MCR is intended to provide crisis supports and services during the first 72 hours of a crisis.

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NOTE: Such initial encounters will be subject to retrospective review. In this way, **if** it is determined that the response time is beyond one – two hours (e.g., next day or later), and/or if available/reviewed documentation does **not** support the crisis, the payment might be subject to recoupment.

Allowed Mode(s) of Delivery

1. Individual;
2. On-site (MCR office); or
3. Off-site.

Allowed Places of Service

This is primarily a community-based service delivered in member’s natural setting with exceptions for office-based when desired or requested by the member. Any exceptions to providing the service in the member’s natural setting must include a justification documented in the member record. When preferred, office-based services are permitted; however, it must not be the primary mode of service delivery. For minors under the age of 18, the member’s natural setting will include but is not limited to a family or foster family home, school, or a group home where the individual currently resides.

Staffing Requirements

The MCR provider shall comply with core staffing requirements within the scope of practice of the license required for the facility or agency to practice in the state of Louisiana. (See Provider Qualifications in the general section.) In addition, the following core staffing requirements for the program must be followed:

1. Medical director or designated prescriber (physician/psychiatrist, APRN, medical psychologist) must be available 24 hours a day, seven days a week for consultation and medication management;
2. Qualified licensed professionals to provide assessment and meet the member’s needs during initial and follow up response; and

NOTE: Qualified licensed professionals possess a current, valid and unrestricted license in the State of Louisiana and are qualified to conduct assessments, in

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accordance with the professional’s permitted scope of practice. Licensed professionals include LMHPs, Provisionally Licensed Professional Counselors (PLPCs), Provisionally Licensed Marriage and Family Therapists (PLMFTs) and Licensed Master Social Workers (LMSWs).

3. RPSS or RFPSS to meet the member’s needs.

Response Team Staffing Requirements

1. A 2-person team must dispatch in person. This must be met by one of the following staffing combinations:
 - a. Two (2) RFPSS or RPSS;
 - b. One (1) RFPSS or RPSS and an unlicensed professional; or
 - c. One (1) RFPSS or RPSS and a qualified licensed professional.
2. If not dispatching in person, the qualified licensed professional shall participate to assess and provide clinical intervention throughout the crisis response via telemedicine; and
3. One staff person may deploy after the initial dispatch and during the period in which follow up is provided (up to 72 hours post initial intervention). The level of staff deployed shall be appropriate to the follow up needs of the member as determined by the qualified licensed professional supervising clinical interventions.

Allowed Provider Types and Specialties

1. PT 74 Mental Health Clinic PS 70 Clinic / Group PSS 8E CSoC/ Behavioral Health;
2. PT 77 Mental Health Rehab PS 78 MHR; and
3. PT AF Crisis Receiving Center, PS 8E CSoC/Behavioral Health.

Exclusions

1. MCR services cannot be rendered in SUD residential facilities or inpatient facilities;

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2. MCR services cannot be approved for incarcerated individuals; and
3. MCR services are not to be utilized as step down services from residential or inpatient psychiatric service settings, or SUD residential service settings.

Billing

1. Only direct staff face-to-face time with the member or family members may be billed for the initial response. MCR is a face-to-face intervention with the member present. Family or other collaterals may also be involved;
2. The initial MCR dispatch per diem covers the first 24 hours. Any follow up provided within the first 24 hours is included in the per diem. MCR follow-up services can only be billed for any additional follow up beyond 24 hours and up to 72 hours after dispatch;
3. Collateral contacts shall involve contacts with family members or other individuals having a primary relationship with the member receiving treatment and must be for the benefit of the member. These contacts are encouraged, included within the rate, and are not billed separately; and
4. Time spent in travel, documenting, supervision, training, etc. has been factored into the indirect unit cost and may not be billed directly.

Behavioral Health Crisis Care (BHCC) (Effective 4/1/2022) for Ages 21 and Older

BHCC services are an initial or emergent psychiatric crisis response intended to provide relief, resolution and intervention through crisis supports and services during the first phase of a crisis for adults. BHCC Centers operate 24 hours a day, seven days a week as a walk-in center providing short-term mental health crisis response, offering a community based voluntary home-like alternative to more restrictive settings, such as the emergency departments, or coercive approaches, such as Physician Emergency Certificates (PECs), law enforcement holds, or Orders of Protective Custody (OPC). BHCC Centers are designed to offer recovery oriented and time limited services up to 23 hours per intervention, generally addressing a single episode that enables a member to return home with community-based services for support or be transitioned to a higher level of care as appropriate if the crisis is unable to be resolved.

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Components

1. Provide services (screening, assessment, interventions, and care coordination) as outlined in the general section;
2. Registered nurse or licensed practical nurse practicing within the scope of their license performs a medical screen to evaluate for medical stability; and
3. Providing follow up to the member and authorized member’s caretaker and/or family within 24 hours as appropriate and desired by the member and up to 72 hours to ensure continued stability post crisis for those not accessing higher levels of care or another crisis service, including but not limited to:
 - a. Telephonic follow-up based on clinical individualized need; and
 - b. Additional calls/visits to the member following the crisis as indicated in order to stabilize the crisis. If the member indicates no further communication is desired, it must be documented in the member’s record.

Eligibility Criteria

The medical necessity for these rehabilitative services must be determined by and services recommended by an LMHP or physician to promote the maximum reduction of symptoms and/or restoration of a member aged 21 years and over to their best age-appropriate functional level. Members in crisis who require this service may be using substances during the crisis, and this substance use will not, in and of itself, disqualify them for eligibility for the service.

All members who self-identify as experiencing a seriously acute psychological/emotional change, that results in a marked increase in personal distress and that exceeds the abilities and the resources of those involved to effectively resolve it, are eligible for initial/emergent crisis services as long as medical necessity is met.

Service Utilization

BHCC is an initial crisis service and is allowed without the requirement of a prior authorization in order to address the emergent issues in a timely manner, although providers are required to notify the MCE when its member presents. BHCC is intended to provide crisis supports and services

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during the first 23 hours of a crisis. If the referral is made from CBCS to BHCC, prior authorization is required.

Allowed Mode(s) of Delivery

1. Individual; and
2. On-site.

NOTE: Such encounters will be subject to retrospective review. In this way, **IF** it is determined that the available/reviewed documentation does **NOT** support the crisis, the payment may be subject to recoupment.

Allowed Places of Service

This is a facility-based service, specifically designed to be welcoming and homelike, and designed to ensure that individuals can be served in an appropriate manner congruent with their needs. Whenever possible, this shall be a stand-alone structure that is not co-located within an institutional setting.

Staffing Requirements

The BHCC Center shall comply with core staffing requirements within the scope of practice of the license required for the facility or agency to practice in the state of Louisiana. (See Provider Qualifications in the general section.) In addition, the following core staffing requirements for the program must be followed:

1. Medical Director or designated prescriber (physician/psychiatrist, APRN, Medical Psychologist) must be available 24 hours a day, seven days a week for consultation and medication management;
2. LMHPs on duty to adequately to meet the member’s needs;
3. RN or LPN on duty to adequately to meet the member’s needs;
4. RPSS on duty to adequately to meet the member’s needs;
5. At least two staff must be present at all times. Clerical staff do not qualify for this requirement; and

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6. Minimum staff to member ratio of 1:4 must be maintained at all times. Staffing must take into consideration the health and safety of the members and staff.

Allowed Provider Types and Specialties

1. PT 74 Mental Health Clinic PS 70 Clinic / Group PSS 8E CSoC/ Behavioral Health;
2. PT 77 Mental Health Rehab PS 78 MHR; and
3. PT AF Crisis Receiving Center, PS 8E CSoC/Behavioral Health.

Exclusions

BHCC is not to be utilized as step down services from other residential or inpatient psychiatric service settings or SUD residential service settings.

The per diem for BHCC and CS cannot be billed on the same day.

Restraints and seclusion cannot be used in a BHCC Center.

BHCC cannot be billed for consecutive days.

Community Brief Crisis Support (CBCS) (Effective 3/1/2022) (expansion to ages under 21 effective 04/01/2024)

CBCS services are an ongoing crisis response intended to be rendered for up to 15 days and are designed to provide relief, resolution and intervention through maintaining the member at home/community, de-escalating behavioral health needs, referring for treatment needs, and coordinating with local providers. CBCS is a face-to-face, time-limited service provided to a member (and for minors, the member’s caregiver) who is experiencing a psychiatric crisis until the crisis is resolved and the member can return to existing services or be linked to alternative behavioral health services. As determined by the MCE, CBCS can also be provided to individuals who have experienced a presentation to an emergency department for a reason related to emotional distress.

CBCS services are available 24 hours a day, seven days a week. CBCS services are not intended for and must not replace existing behavioral health services. Rather, referrals for services occur directly from MCEs, MCR, BHCC, or CS providers as needed for ongoing follow up and care.

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This level of care involves supporting and collaborating with the member (and for minors, the member’s caregiver) to achieve symptom reduction by problem solving and developing useful safety plans that will assist with community tenure.

Components

1. Provide services (screening, assessment, interventions, and care coordination) as outlined in the general section; and
2. Providing follow up to the member and authorized member’s caretaker and/or family within 24 hours as appropriate and desired by the member and up to 15 days following presentation to an emergency department for a reason related to emotional distress or initial contact with the CBCS provider once the previous crisis provider (MCR, BHCC, CS) has discharged the member to ensure continued stability post crisis for those not accessing higher levels of care, including but not limited to:
 - a. Telephonic or face to face follow-up based on clinical individualized need, with face to face follow-up highly preferred for service delivery to individuals under the age of 21; and
 - b. Additional calls/visits to the member following the crisis as indicated in order to stabilize the crisis. If the member indicates no further communication is desired, it must be documented in the member’s record.

Eligibility Criteria

The medical necessity for these rehabilitative services must be determined by and services recommended by an LMHP or physician to promote the maximum reduction of symptoms and/or restoration of a member to their best age-appropriate functional level. This service will be rendered to eligible members after a referral is made from the MCE, MCR, BHCC, or CS provider. Members in crisis who require this service may be using substances during the crisis, and this substance use will not, in and of itself, disqualify them for eligibility for the service.

All members who self-identify as experiencing a seriously acute psychological/emotional change, that results in a marked increase in personal distress and that exceeds the abilities and the resources of those involved to effectively resolve it, are eligible for ongoing crisis services as long as medical necessity is met and the members is not already linked to an existing MHR or ACT provider.

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For minors under the age of 18, eligibility for crisis services based on “self-identification” that the member is experiencing a crisis includes identification by the minor’s caregiver. CBCS can be requested by any caregiver and delivered in any setting as defined in the MCR section, above, as long as there is consent for treatment from an individual legally allowed to consent to treatment of the minor.

Service Utilization

CBCS requires prior authorization, is based on medical necessity, and is intended to assure ongoing access to medically necessary crisis response services and supports until the current crisis is resolved, or until the member can access alternative behavioral health supports and services. The member’s treatment record must reflect relief, resolution and problem solving of the identified crisis or referral to an alternate provider. Additional units may be approved with prior authorization.

Allowed Mode(s) of Delivery

1. Individual;
2. On-site (CBCS office); or
3. Off-site.

Allowed Places of Service

CBCS is primarily a community-based service delivered in member’s natural setting with exceptions for office-based settings when desired or requested by the member or through some other exception as documented in the member record. When preferred, office-based services are permitted, but shall not be the primary mode of service delivery. For minors under the age of 18, the member’s natural setting will include, but is not limited to, a family or foster family home, school, or a group home where the minor currently resides.

Staffing Requirements

The CBCS provider shall comply with core staffing requirements within the scope of practice of the license required for the facility or agency to practice in the state of Louisiana. (See Provider Qualifications in the general section.) In addition, the following core staffing requirements for the program must be followed:

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1. Medical director or designated prescriber (physician/psychiatrist, APRN, medical psychologist) must be available 24 hours a day, seven days a week for consultation and medication management;
2. LMHPs on duty to adequately meet the member's needs; and
3. RPSS or RFPSS on duty to adequately meet the member's needs.

Allowed Provider Types and Specialties

1. PT 74 Mental Health Clinic PS 70 Clinic / Group PSS 8E CSoC/ Behavioral Health;
2. PT 77 Mental Health Rehab PS 78 MHR; and
3. PT AF Crisis Receiving Center, PS 8E CSoC/Behavioral Health.

ExclusionsCBCS services **cannot be:**

1. Rendered in SUD residential facilities, PRTF, or inpatient facilities;
2. Approved for incarcerated individuals; or
3. Utilized as step down services from other residential or inpatient psychiatric service settings.

CBCS services **must not** duplicate already-approved and accessible behavioral health services with a member's already-established ACT, CPST, or PSR provider. However, this shall not prohibit a brief overlap of services that is necessary for a warm handoff to the accepting provider, when appropriate.

Billing

1. **Only direct staff face-to-face, in-person time with the member may be billed.** CBCS is a face-to-face intervention with the member present; family or other collaterals may also be involved;
2. Time spent in travel, documenting, supervision, training, etc. has been factored into the indirect unit cost and may not be billed directly; and

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3. CBCS and established behavioral health services may be billed on the same day one time to allow for the hand off.

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Individual Placement and Support

Individual Placement and Support (IPS) refers to the evidence-based practice of supported employment for members with mental illness. IPS helps members living with mental health conditions work at regular jobs of their choosing that exist in the open labor market and pay the same as others in a similar position, including part-time and full-time jobs. IPS helps people explore the world of work at a pace that is right for the member. Based on member's interests, IPS builds relationships with employers to learn about the employers' needs in order to identify qualified job candidates.

The job search is based on individual preferences, strengths, and work experiences, not on a pool of jobs that are readily available or the IPS specialist's judgment. Job seekers indicate preferences for job type, work hours, and types of job supports. Job supports are individualized based on the needs of the member and what will promote a positive work experience. IPS offers help with job changes, career development and career advancement, including additional schooling and training, assistance with education, a more desirable job, or more preferred job duties. The majority of IPS services must be provided in the community.

IPS provides competitive job options that have permanent status rather than temporary or time-limited status. Competitive jobs pay at least minimum wage, are jobs that anyone can apply for and are not set aside for people with disabilities. IPS offers to help with another job when one has ended, regardless of the reason that the job ended or number of jobs held. Some people try several jobs before finding employment they like. Each job is viewed as a positive learning experience. If a job is a poor match, an IPS specialist offers to help the member find a new job based upon lessons learned. IPS follows the philosophy that all choices and decisions about work, further schooling, technical training and support are individualized based on the member's preferences, strengths, and experiences. In IPS, members are encouraged to be as independent as possible and IPS specialists offer support as needed.

Evaluation of the Evidence Based Practice

Research has demonstrated that this method of supported employment is the most effective approach for helping people with serious mental illness who want to work in regular jobs. Evidence to support IPS can be found at <https://ipsworks.org/index.php/evidence-for-ips/>.

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Components

Each IPS specialist carries out all phases of employment service, including intake, engagement, assessment, job placement, job coaching, and follow-along supports before step down to less intensive employment support from another mental health practitioner.

The IPS model is based on an **integrated team approach which includes the following:**

1. IPS programs are staffed by IPS specialists, who meet frequently with the mental health treatment team to integrate IPS services with mental health treatment. Louisiana Rehabilitation Services (LRS) counselors also work closely with IPS specialists to ensure that members receive services that are coordinated. Please note: Prior to providing members with IPS services, IPS specialists shall document in the member's file that IPS services are not available to the member through LRS. IPS specialists with a caseload of nine (9) or fewer members participate in bi-weekly client-based individual or group supervision and mental health treatment team meetings for each team to which they are assigned. Once IPS specialists have a caseload of ten (10) or more members, they participate in weekly client-based individual or group supervision, and mental health treatment team meetings for each team to which they are assigned:
 - a. The employment unit has **weekly client-based individual or group supervision** following the supported employment model in which strategies are identified and job leads are shared. They provide coverage for each other's caseload when needed;
 - b. IPS specialists **attach to one (1) or two (2) mental health treatment teams**, from which at least 90% of the employment specialist's caseload is comprised;
 - c. IPS specialists actively participate in **weekly mental health treatment team meetings** (not replaced by administrative meetings) that discuss individual members and their employment goals with shared decision-making; and
 - d. The IPS specialists and LRS counselors have frequent contact for the purpose of discussing shared members and identifying potential referrals. IPS specialists actively participate in **monthly LRS meetings** if there is a shared member.

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2. Members are not asked to complete vocational evaluations (e.g., paper and pencil vocational tests, interest tests, and work samples), situational assessments (such as short-term work experiences), prevocational groups, volunteer jobs, short-term sheltered work experiences, or other types of assessment in order to receive assistance obtaining a competitive job;
3. **Initial vocational assessment (referred to as the “career profile”) occurs over 2-3 sessions** and is updated with information from work experiences in competitive jobs and aims at problem solving using environmental assessments and consideration of reasonable accommodations, such as but not limited to American Disability Act (ADA) requirements to encourage an atmosphere of productivity considering the member’s diagnosis;
4. A vocational assessment/career profile form that includes information about preferences, experiences, skills, current adjustment, strengths, personal contacts, etc., is updated with each new job experience. Sources of information include the member, treatment team, clinical records, and, with the member’s permission, from family members and previous employers. The vocational assessment/career profile leads to individualized employment and education planning. The career profile is updated with each new employment and education experience. The purpose is not to determine employability, but to learn what the member enjoys, skills and experiences, and what will help the member achieve goals. **Initial vocational assessment occurs within 30 days after program entry;**
5. **An individualized job search plan** is developed and updated with information from the vocational assessment/career profile form and new job/educational experiences;
6. IPS specialists **systematically visit employers**, who are selected based on the job seeker’s preferences, to learn about their business needs and hiring preferences. Each IPS specialist makes at least **6 face-to-face employer contacts per week** on behalf of members looking for work. An employer contact is counted even when an employment specialist meets the same employer more than one time in a week, and when the member is present or not present. Member-specific and generic contacts are included. IPS specialists use **a weekly tracking form to document employer contacts;**
7. IPS programs use a rapid job search approach to help job seekers obtain jobs rather than assessments, training, and counseling. IPS specialists help members look for

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jobs soon after entering the program instead of requiring pre-employment assessment and training or intermediate work experiences, such as prevocational work units, short-term jobs to assess skills, transitional employment, agency-run businesses or sheltered workshops. **The first face to face contact with the employer by the member or the IPS specialist occurs within 30 days;**

8. IPS specialists ensure that members are offered comprehensive and personalized benefits planning, including information about how work may affect their disability and government benefits. The purpose is to help members make informed decisions about job starts and changes. In all situations members are encouraged to consider how working and developing a career may be the quickest way to avert poverty or dependence on benefits. All members are **offered assistance in obtaining comprehensive, individualized work incentives (benefits) planning before starting a new job** and assistance accessing work incentives planning thereafter when making decisions about changes in work hours and pay. Work incentives planning includes SSA benefits, medical benefits, medication subsidies, housing subsidies, food stamps, spouse and dependent children benefits, past job retirement benefits, and any other sources of income;
9. Job supports are individualized and continue for as long as each worker wants and needs the support. Members receive different types of support for working a job that are based on the job, member preferences, work history, needs, etc. Once members obtain employment, the IPS specialist and staff from the mental health treatment team provide support as long as members want and benefit from the assistance. The goal is for each member to work as independently as possible and transition off the IPS caseload when the member is comfortable and successful in their work life;
 - a. IPS specialists **have face-to-face contact within one (1) week before starting a job, within three (3) days after starting a job, weekly for the first month, and documented efforts to meet with members at least monthly for a year or more, on average, after working steadily, and desired by members; and**
 - b. Members are transitioned to step down job supports from a mental health worker following steady employment. IPS specialists **contact members within three (3) days of learning about the job loss.** IPS specialists also

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provide employer support (e.g., educational information, job accommodations) at a member's request.

10. Service termination is not based on missed appointments or fixed time limits:
 - a. **Engagement and outreach attempts** made by integrated team members **are systematically documented, including multiple home/community visits, coordinated visits by IPS specialist with integrated team member, and contacts with family**, when applicable; and
 - b. Once it is clear that the member no longer wants to work or continue with IPS services, the IPS specialist stops outreach.

Eligibility Criteria

Medicaid eligible members who meet medical necessity criteria in accordance with LAC 50:I.1101 may receive IPS when recommended by an LMHP or physician within their scope of practice. Members must be:

1. At least 21 years of age; and
2. Transitioned from a nursing facility or been diverted from nursing facility level of care through the My Choice Louisiana program.

All members meeting the above criteria who are interested in working have access to this service. Members are not excluded on the basis of job readiness, diagnoses, symptoms, substance use history, mental health symptoms, history of violent behavior, cognition impairment, treatment non-adherence, work history, psychiatric hospitalizations, homelessness, level of disability, legal system involvement, or personal presentation.

Service Utilization

Services are subject to prior authorization. Providers shall submit sufficient documentation to determine medical necessity. Failure to do so may result in a partial or non-authorization for services. Services may be provided at a facility or in the community as outlined in the treatment plan.

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Service Delivery

There shall be member involvement throughout the planning and delivery of services. Services shall be:

1. Delivered in a culturally and linguistically competent manner;
2. Respectful of the member receiving services;
3. Appropriate to members of diverse racial, ethnic, religious, sexual and gender identities and other cultural and linguistic groups; and
4. Appropriate for age, development, and education.

Any licensed practitioner providing behavioral health services must operate within their license and scope of practice.

Staff Ratios

One (1) full time employment specialist to 20 active members.

Allowed Provider Types and Specialties

PT 74 Mental Health Clinic PS 70 Clinic / Group PSS 8E CSoC/ Behavioral Health.

Allowed Modes of Delivery

1. Individual;
2. On-site; and
3. Off-site.

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The IPS unit has weekly member-based individual or group supervision following the supported employment model in which strategies are identified and job leads are shared. They provide coverage for each other's caseload when needed. When there is good fidelity to this item, the IPS supervisor meets weekly with all the IPS specialists as a group to review client employment goals and progress towards achieving those goals. See Components section number 1 for information regarding caseload and supervision.

IPS specialists share ideas to help members meet their goals. IPS specialists also share job leads during the meeting and occasionally introduce each other to employers. IPS specialists have discrete caseloads but provide back up and support for other IPS specialists as needed. IPS specialists' skills are developed and improved through **outcome-based supervision**.

All five (5) key roles of the IPS supervisor are present as follows:

1. One full-time (FTE) supervisor is responsible for **no more than 10 IPS specialists**. The supervisor does not have other supervisory responsibilities. (IPS supervisors supervising fewer than ten (10) IPS specialists may spend a percentage of time on other supervisory activities on a prorated basis. For example, an IPS supervisor responsible for 4 IPS specialists may be devoted to IPS supervision half time);
2. Supervisor conducts **weekly supervision** designed to review member situations and identify new strategies and ideas to help members with their work lives. Either **individual or group supervision is sufficient**. New IPS specialists often benefit from weekly individual supervision while experienced IPS specialists often appreciate the support of individual supervision at least once or twice monthly;
3. Supervisor communicates with mental health team leaders to ensure that services are integrated, to problem-solve programmatic issues, (such as referral issues or transfer of follow-along to mental health workers), and to be a champion for the value of work. **Supervisor attends a meeting for each mental health treatment team on a quarterly basis;**

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4. Supervisor **accompanies IPS specialists, who are new or having difficulty with job development, in the field monthly** to improve skills by observing, modeling, and giving feedback on skills, e.g., meeting employers for job development; and
5. Supervisor **reviews current member outcomes** (e.g., job starts, number and percent of people working, number/percent of people in education programs, etc.) with IPS specialists **and sets goals to improve program performance at least quarterly.**

Provider Qualifications

IPS must be provided only under the administrative oversight of licensed and accredited local governing entities (LGEs). Providers must meet state and federal requirements for providing IPS.

Agency

To provide IPS, agencies must meet the following requirements:

1. Be licensed – pursuant to La. R.S. 40:2151, *et. seq.*;
2. Be Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or The Joint Commission (TJC). Denial, loss of, or any negative change in accreditation status must be reported in writing immediately upon notification to the managed care entities with which the agency contracts or is being reimbursed;

NOTE: Agencies must apply for accreditation and pay accreditation fees prior to being contracted and reimbursed by a Medicaid managed care entity, and must maintain proof of accreditation application and fee payment. Agencies must attain full accreditation within eighteen (18) months of the initial accreditation application date.

3. Arrange for and maintain 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 following:
 - a. La. R.S. 40:1203.1 *et seq.* associated with criminal background checks of un-licensed workers providing patient care;
 - b. La. R.S. 15:587, as applicable; and

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- c. Any other applicable state or federal law.
- 4. 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:
 - a. 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; and
 - b. Results of criminal background checks are to be maintained in the individual’s personnel record. Evidence of the individual passing the criminal background check requirements must be maintained on file with the provider agency;
- 5. 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;
 - a. Once employed, the lists must be checked on a once a month basis, 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’ OIG; and
 - b. 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’ OIG.
- 6. Maintain results 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>;
- 7. Arranges for and maintain documentation that all employment specialists, prior to employment, are free from Tuberculosis (TB) in a communicable state as defined by the LAC 51:II.Chapter 5 to reduce the risk of such infections in members and

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staff. Results from testing performed over thirty (30) days prior to date of employment will not be accepted as meeting this requirement;

8. Establish and maintain written policies and procedures inclusive of drug testing staff to ensure an alcohol and drug-free workplace and a workforce free of substance use (See Appendix D);
9. Maintain documentation that all staff providing direct care, who are required to complete First Aid and cardiopulmonary resuscitation (CPR), complete American Heart Association (AHA) recognized training within ninety (90) days of hire, which shall be renewed within a time period recommended by the AHA (See Appendix D);
10. Maintain documentation of verification of completion of required trainings and certifications for all IPS staff;
11. Ensure and maintain documentation that all persons employed by the organization complete training in a state recognized Crisis Intervention curriculum prior to handling or managing crisis responses, which shall be updated annually. (See Appendix D for list of trainings); and
12. Has a National Provider Identification (NPI) number, and must include the agency NPI number and the NPI number of the individual rendering IPS on its behalf on all claims for Medicaid reimbursement, where applicable.

IPS Fidelity Standards

IPS teams must meet fidelity standards as evidenced by the Supported Employment Fidelity Review Manual found at <https://ipsworks.org/wp-content/uploads/2019/12/Final-Fidelity-Manual-Fourth-Edition-112619.pdf>. When an agency has more than one IPS team, separate reviews are scheduled for each team. A team consists of a group of IPS specialists who report to one supervisor.

New Teams

New IPS teams must:

1. Submit documentation to the MCO for contracting purposes including evidence of fidelity to the model including findings of self-evaluation using the IPS Fidelity Scale, which may be found at the following website: <https://ipsworks.org/wp-content/uploads/2017/08/IPS-Fidelity-Scale-Eng1.pdf>;

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- a. The self-evaluation must reflect a baseline score in order for new IPS teams to be eligible to provide Medicaid funded services to members.
2. Undergo a fidelity review using the IPS Fidelity Scale by an MCO-identified third party within six (6) months of implementation:
 - a. This review must reflect continued improvement toward the desired score of 100 (good fidelity);
 - b. The team will implement an MCO approved corrective action plan immediately for any individual IPS Fidelity Scale criterion that rates a one (1), two (2), or three (3);
 - c. 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; and
 - d. Fidelity is tested every six (6) months for a new program until a score of 100 is reached.

Existing teams

Once a new team achieves a fidelity review score of 100 or above, that team is considered an existing team and must:

1. Participate in fidelity reviews using the IPS Fidelity Scale conducted by the MCO or designee at least annually (every twelve (12) months) or more frequently as prescribed by the MCO; and
2. Maintain a minimum score of 100 and above on the IPS Fidelity Scale or the team will implement a MCO approved corrective action plan and achieve a minimum score of 100 on the IPS Fidelity Scale within six (6) months in order to maintain the ability to accept new clients.

If a 115 to 125 on the IPS Fidelity Scale is achieved, the team will be deemed as operating with “exceptional practice.” MCOs may grant extensions of twenty-four (24) month intervals between fidelity reviews for teams operating with “exceptional practice.”

Teams are considered to be operating below acceptable fidelity thresholds if they are achieving less than 100 on the IPS Fidelity Scale after implementing a MCO approved corrective action plan for

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six (6) months 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 an MCO approved corrective action plan and undergo another fidelity review within six (6) months by the MCO or designee. If the team achieves at least 100 on the IPS Fidelity Scale in subsequent review, the team can resume accepting new referrals.

Staff

Individuals providing IPS must operate under the administrative oversight of a licensed and accredited LGE. IPS Specialists must:

1. Complete continuing education in confidentiality requirements, Health Insurance Portability and Accountability Act (HIPAA) requirements and mandated reporting;
2. Have a satisfactory completion of criminal background checks 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;
3. Not be excluded from participation in the Medicaid or Medicare program by Louisiana Medicaid or the Department of Health and Human Services OIG;
4. Not have a finding on the Louisiana State Adverse Action List;
5. Pass a TB test prior to employment in accordance with the LAC 51:II.Chapter 5; OR be free from Tuberculosis (TB) in a communicable state as defined by the LAC 51:II.Chapter 5;
6. Pass drug screening tests as required by provider agency's policies and procedures;
7. Complete American Heart Association (AHA) recognized First Aid and CPR training. Psychiatrists, APRNs, PAs, RNs and LPNs are exempt from this training (See Appendix D); and
8. Non-licensed direct care staff are required to complete a basic clinical competency training program approved by OBH prior to providing the service. (Refer to Appendix D).

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Staffing Requirements

At least one dedicated IPS specialist and an IPS supervisor comprise the employment unit. Peer specialists are members of some IPS teams, who share their own experiences to inspire others to work and build careers.

The requirements for IPS specialists and IPS supervisors are indicated as follows:

IPS Specialist

1. High school diploma is required;
2. Two years post high school experience in employment;
3. One year experience working with people with severe mental illness;
4. Successfully completed IPS training prior to providing services; and
5. Have current IPS Certification or achieve certification within two (2) years.

IPS Peer Specialist (Optional staff, but recommended)

1. Must be a Peer Support Specialist as defined in Section 2.3: Outpatient Services – Peer Support Services; and
2. Have current IPS Certification or achieve certification within four (4) years.

IPS Supervisor

1. Master’s degree in rehabilitation counseling or mental health field is preferred; Bachelor’s degree is required. Previous experience as an employment specialist is necessary;
2. Experience working with people with severe mental illness;
3. At least one (1) year experience in employment services;

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4. Successfully completed IPS training prior to providing services; and
5. Have current IPS certification, or achieve certification within two (2) years.

IPS Training and Recertification

IPS staff must obtain IPS Certification (CIPS) within two (2) years of employment as an IPS specialist and maintain certification thereafter. Information on IPS Certification and trainings are available at www.IPSworks.org.

Limitations/Exclusions

1. IPS services shall not duplicate any other Medicaid State Plan service or service otherwise available to the member at no cost;
2. Members receiving IPS are not served by LRS except to receive services not covered under IPS such as assistive technology devices/software, home and vehicle modifications, occupational exams/license, tools/equipment, transportation, and uniforms. There must be documentation in the member's file that IPS services are not available from programs funded under section 110 of the Rehabilitation Act of 1973; and;
3. Incentive payments, subsidies, or unrelated vocational training expenses may not be billed such as but not limited to: incentive payments made to an employer to encourage or subsidize the employer's participation in a IPS program; payments that are passed through to users of IPS programs; or payments for vocational training that is not directly related to a member's IPS program.

Billing

IPS service is a bundled rate that includes all of the components outlined above in a given month.

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Outpatient Therapy by Licensed Practitioners

Licensed practitioner outpatient therapy includes:

1. Outpatient psychotherapy (individual, family and group);
2. Psychotherapy for crisis;
3. Psychoanalysis;
4. Electroconvulsive therapy;
5. Biofeedback;
6. Hypnotherapy;
7. Screening, assessment, examination, and testing;
8. Diagnostic evaluation;
9. Medication management; and
10. Case conference* (Coordinated System of Care (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 of psychiatric conditions.

Provider Qualifications

Licensed mental health practitioners are licensed individuals who are in good standing in the state of Louisiana to practice within the scope of all applicable state laws, practice acts, and the practitioner’s professional license. Licensed mental health practitioners include the following individuals:

1. Licensed mental health professionals (LMHP) who are licensed in the State of Louisiana to diagnose and treat mental illness or substance use disorders. An LMHP includes the following individuals who are licensed to practice independently:

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- a. Medical psychologists;
 - b. Licensed psychologists;
 - c. Licensed clinical social workers (LCSWs);
 - d. Licensed professional counselors (LPCs);
 - e. Licensed marriage and family therapists (LMFTs);
 - f. Licensed addiction counselors (LACs); and
 - g. Advanced practice registered nurses (APRNs).
2. Provisionally licensed professional counselors (PLPCs);
 3. Provisionally licensed marriage and family therapists (PLMFTs); and
 4. Licensed master social workers (LMSWs).

LPCs may render or offer prevention, assessment, diagnosis, and treatment, which includes psychotherapy of mental, emotional, behavioral, and/or addiction disorders to individuals, groups, organizations, or the general public by a licensed professional counselor, which is consistent with their professional training as prescribed by La. R.S. 37:1101 *et seq.* 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).

PLPCs shall have a valid, current and unrestricted license issued by the Louisiana Board of Professional Counselors. PLPCs shall deliver services in accordance with the current, applicable scope of practice and must be actively engaged in supervision as required by their respective licensing board. (Reference: Louisiana Mental Health Counselor Licensing Act, La R.S. 37:1101 *et seq.*)

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 their professional training as prescribed by La. R.S. 37:1101 *et seq.* LMFTs shall not engage in the practice of psychology or prescribe, either orally or in writing, distribute, dispense, or

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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.

PLMFTs shall have a valid, current and unrestricted license issued by the Louisiana Board of Professional Counselors. PLMFTs shall deliver services in accordance with the current, applicable scope of practice and must be actively engaged in supervision as required by their respective licensing board. (Reference: Louisiana Mental Health Counselor Licensing Act, La R.S. 37:1101 *et seq.*)

LMSWs shall have a valid, current and unrestricted license issued by the Louisiana Board of Social Worker Examiners. LMSWs shall deliver services in accordance with the current, applicable scope of practice and must be actively engaged in supervision as required by their respective licensing board. (Reference: Louisiana Social Work Practice Act, La R.S. 37:2701 *et seq.*)

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.

Physician must be a psychiatrist or physician's assistant working under protocol of a psychiatrist.

NOTE: Psychiatrists are covered under the physician section of the Louisiana Medicaid State Plan. However, psychiatrists often are employed by agencies that employ other licensed practitioners. For ease of reference, psychiatrist codes often billed under agencies are included in this section of the provider manual. However, psychiatrists may bill any codes under the physician section of the Louisiana Medicaid State Plan for which they may be qualified. Note that prior authorization or authorization beyond an initial authorization level of benefit is not a required CMS element for psychiatrist services under the Louisiana Medicaid State Plan; however, the managed care entity may choose to require prior authorization for psychiatrist services or may prior authorize psychiatrist services beyond an initial authorization level of benefit at their option.

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In general, the following Medicaid Enterprise Systems (MES) provider types and specialties may bill these codes according to the scope of practice outlined under State Law. The specific provider types and specialties are permitted to bill each code as noted in the Specialized Behavioral Health Fee Schedule.

Allowed Provider Types and Specialties

1. PT 77 Mental Health Rehab PS 78 MHR;
2. PT 74 Mental Health Clinic PS 70 Clinic / Group;
3. PT 68 Substance Use and Alcohol Use Center PS 70 Clinic/Group;
4. PT 38 School Based Health Center PS 70 Clinic/Group;
5. PT 31 Psychologist PS:
 - a. 6A Psychologist – Clinical;
 - b. 6B Psychologist – Counseling;
 - c. 6C Psychologist – School;
 - d. 6D Psychologist – Developmental;
 - e. 6E Psychologist - Non-declared;
 - f. 6F Psychologist – Other; and
 - g. 6G Psychologist – Medical.
6. PT 73 Social Worker (Licensed/Clinical) PS 73 Social Worker;
 - a. 73 Licensed Clinical Social Worker (LCSW); and
 - b. LL Lower Level – Licensed Master Social Worker (LMSW).

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7. PT AK Licensed Professional Counselor (LPC) PS:
 - a. 8E CSoC/Behavioral Health – LPC; and
 - b. LL Lower Level – Provisionally Licensed Professional Counselor (PLPC).
8. PT AH Licensed Marriage & Family Therapists (LMFT) PS:
 - a. 8E CSoC/Behavioral Health – LMFT; and
 - b. LL Lower Level – Provisionally Licensed Marriage and Family Therapist (PLMFT).
9. PT AJ Licensed Addiction Counselor PS 8E CSoC/Behavioral Health;
10. PT 20 Psychiatrist PS:
 - a. 26 Psychiatry; and
 - b. 2W Addiction Specialist.
11. PT 78 Nurse Practitioner (APRN) PS 26;
12. PT 93 Clinical Nurse Specialist (APRN) PS 26; and
13. PT 94 Physician Assistant PS 26.

Eligibility Criteria

All Medicaid-eligible children and adults who meet medical necessity criteria.

Limitations/Exclusions

Providers cannot provide services or supervision under this section if they are a provider who is excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act. In addition, they may not be debarred, suspended or otherwise excluded from participating in procurement activities under the State and federal laws, regulations

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and policies, including the federal Acquisition Regulation, and Executive Order No.12549. In addition, providers who are an affiliate, as defined in the federal Acquisition Regulation, of a person excluded, debarred, suspended or otherwise excluded under State and federal laws, regulations and policies may not participate.

All services must be authorized. Services which exceed the limitation of the initial authorization must be approved for re-authorization prior to service delivery.

Service providers that offer addiction services must demonstrate competency, as defined by LDH, State law (La. R.S. 37:3386, *et seq.*) and regulations. Anyone providing addiction or behavioral health services must be adhering to their scope of practice license.

Individuals who reside in an institution (inpatient hospital setting) or secured settings such as jails and prisons, are not permitted to receive rehabilitation services. Visits to intermediate care facilities for the intellectually disabled are not covered. All licensed practitioner services provided while a person is a resident of an institute for mental disease (IMD), such as a free-standing psychiatric hospital or psychiatric residential treatment facility, are the content of the institutional service and not otherwise separately reimbursable by Medicaid.

Billing

LMSWs, PLPCs and PLMFTs may not directly bill for services provided to a Medicaid enrollee. LMSWs, PLPCs and PLMFTs may be the rendering provider on a claim when in accordance with Title 46 and their individual practice acts.

Allowed Mode(s) of Delivery

1. Individual;
2. Family;
3. Group;
4. On-site;
5. Off-site; and
6. Tele-video.

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Additional Service Criteria

Services provided to children and youth must include communication and coordination with the family and/or legal guardian, as well as the primary care physician (PCP). Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the youth’s treatment record.

Psychological testing must be prior authorized by the MCO.

Telehealth

Telemedicine/telehealth is the use of a telecommunications system to render healthcare services when a physician or licensed practitioner and a member are not in the same location. Telehealth does **NOT** include the use of text, e-mail, or facsimile (fax) for the delivery of healthcare services.

The originating site means the location of the member at the time the telehealth services are provided. There is no restriction on the originating site and it can include, but is not limited to, a healthcare facility, school, or the member’s home. Distant site means the site at which the physician or other licensed practitioner is located at the time the telehealth services are provided. Assessments, evaluations, individual psychotherapy, family psychotherapy, and medication management services may be provided via telecommunication technology when the following criteria is met:

1. The telecommunication system must be secure, ensure member confidentiality, and be compliant with the requirements of the Health Insurance Portability and Accountability Act (HIPAA);
2. The services provided are within the practitioner’s telehealth scope of practice as dictated by the respective professional licensing board and accepted standards of clinical practice;
3. The member’s record includes informed consent for services provided through the use of telehealth;
4. Services provided using telehealth must be identified on claims submission using by appending the modifier “95” to the applicable procedure code and indicating the correct place of service, either POS 02 (other than home) or 10 (home). Both the correct POS and the 95 modifier must be present on the claim to receive reimbursement;

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5. Assessments and evaluations conducted through telehealth should include synchronous, interactive, real-time electronic communication comprising both audio and visual elements unless clinically appropriate and based on member consent;
6. Providers must deliver in-person services when telehealth is not clinically appropriate or when the member requests in-person services;
7. Group psychotherapy is only allowed via telehealth when utilized for Dialectical Behavioral Therapy (DBT) and must include synchronous, interactive, real-time electronic communication comprising of both audio and visual elements.

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Peer Support Services

Peer support services (PSS) are evidence-based behavioral health services that consist of qualified peer support providers, who assist members with their recovery from mental illness and/or substance use disorders. PSS are provided by Office of Behavioral Health (OBH) recognized peer support specialists (RPSS)/credentialed peer support specialists (CPSS). These specialists possess personal lived experience with recovery from behavioral health conditions and successfully navigating the behavioral health services system.

PSS are:

1. Behavioral health rehabilitative services to reduce the disabling effects of an illness or disability and restore the member to the best possible functional level in the community;
2. Person-centered and recovery focused; and
3. Face-to-face interventions with the member present. Most contacts occur in community locations where the member lives, works, attends school and/or socializes.

PSS, or consumer-operated services, are recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA) as an evidence-based practice. PSS are designed on the principles of individual choice and the active involvement of members in their own recovery process. Peer support practice is guided by the belief that people with mental illness and substance use disorders need opportunities to identify and choose for themselves their desired roles with regard to living, learning, working and social interaction in the community.

Evaluation of the Evidence Based Practice

Research studies have supported the value and benefits of integrating PSS into the behavioral health services array as having a positive impact on outcomes, as well as the cost effectiveness of the service. The following are related studies:

1. Annotated bibliography of current research on the effectiveness of peers. Conducted by BRSS TACS in November 2019. Available at: <https://c4innovates->

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2. Recovery Research Review (2014). Conducted by BRSS TACS. Available at: https://c4innovates-my.sharepoint.com/:w:/p/jbushell/EZKFIEdnGQ9Pp0py-6zxdZABBoJ661kkxYEBBg_U3KH43g?e=h7VXV9.

Components

PSS include a range of tasks to assist the member during the recovery process. Recovery planning assists members in setting and accomplishing goals related to their home, work, community and health. PSS may include, but are not limited to:

1. Utilizing ‘lived experience’ to translate and explain the recovery process step by step and expectations of services;
2. Assisting in the clinical process through:
 - a. Providing feedback to the treatment team regarding identified needs and the level of engagement of the member;
 - b. Developing of goals;
 - c. Acting as an advocate, with permission of the member, in the therapeutic alliance between the provider and the member;
 - d. Encouraging members with a low level of engagement to become actively involved in treatment; and
 - e. Ensuring that members are receiving the appropriate services of their choice in a manner consistent with confidentiality regulations and professional standards of care.
3. Rebuilding, practicing, and reinforcing skills necessary to assist in the restoration of the member’s health and functioning throughout the treatment process;
4. Providing support to members and assisting them with participation and engagement in meetings and appointments;
5. Assisting the member in effectively contributing to planning and accessing services to aid in the member’s recovery process;
6. Aiding the member in identifying and overcoming barriers to treatment, and supporting the member in communicating these barriers to treatment and service providers;

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7. Assisting the member with supporting strategies for symptom/behavior management;
8. Supporting members in better understanding their diagnoses and related symptoms;
9. Assisting the member with finding and using effective psychoeducational materials;
10. Assisting the member in identifying and practicing self-care behaviors, including but not limited to developing a wellness recovery plan and relapse prevention planning;
11. Explaining service and treatment options;
12. Assisting the member in developing support systems with family and community members;
13. Serving as an advocate, mentor, or facilitator for resolution of personal issues and reinforcement of skills necessary to enhance and improve the member’s health;
14. Fostering the member in setting goals, promoting effective skills building for overall health, safety and wellbeing that support whole health improvements and achievements of identified goals and healthy choices;
15. Functioning as part of the member’s clinical team to support the principles of self-direction to:
 - a. Assist and support the member to set goals and plan for the future;
 - b. Propose strategies to help the member accomplish tasks or goals; and
 - c. Support the member to use decision-making strategies when choosing services and supports.
16. Providing support necessary to ensure the member’s engagement and active participation in the treatment planning process;
17. Supporting the member to arrange services that will assist them to meet their treatment plan goals, inclusive of identifying providers such as:
 - a. Primary care services;
 - b. Behavioral health management and treatment services;
 - c. Local housing support programs;
 - d. Supportive employment;
 - e. Education, other supportive services;

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- f. Referral to other benefit programs;
 - g. Arranging non-emergency medical transportation; and
18. Providing support with transitioning members from a nursing facility and adjustment to community living.

Eligibility Criteria

Medicaid-eligible members who meet medical necessity criteria may receive PSS when recommended by a licensed mental health professional (LMHP) or physician within their scope of practice. Members must meet the following criteria:

- 1. Be 21 years of age or older; and
- 2. Have a mental illness and/or substance use disorder diagnosis.

In addition to the above criteria, to be eligible to receive PSS from an Office of Aging and Adult Services (OAAS) certified permanent supportive housing (PSH) provider agency, members must:

- 1. Currently receive PSH services; or
- 2. Have transitioned from a nursing facility or been diverted from nursing facility level of care (NFLOC) through the My Choice Louisiana program.

Allowed Modes of Delivery

- 1. Individual;
- 2. Group;
- 3. On-site; and
- 4. Off-site.

Service Utilization

Service authorization is required for peer services exceeding 24 units of service. Such initial encounters may be subject to retrospective review. If it is determined the service was not medically

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necessary, the payment may be subject to recoupment. It is recommended the provider submit the Service Authorization Request for additional peer services as warranted directly following the initial encounter to ensure sufficient time to process the request.

Providers shall submit sufficient documentation to determine medical necessity with the authorization request. Failure to do so may result in a partial or non-authorization for services. Services may be provided at a facility or in the community as outlined in the treatment plan.

Service Delivery

Member involvement is required throughout the planning and delivery of services. Services must be:

1. Delivered in a culturally and linguistically competent manner;
2. Respectful of the member receiving services;
3. Appropriate to members of diverse racial, ethnic, religious, sexual and gender identities and other cultural and linguistic groups; and
4. Appropriate for age, development, and education.

Any licensed practitioner providing behavioral health services must operate within their license and scope of practice.

Staff Ratios

1. One (1) RPSS/CPSS to twenty-five (25) active members; and
2. One (1) RPSS/CPSS to twelve (12) members is maximum group size for adults:
 - a. Peer-facilitated group sessions shall focus on the topic areas identified in the Components section above to assist the member during the recovery process and comply with all areas of the service definition.

Provider Responsibilities

All services shall be delivered in compliance with federal and state laws and regulations, the relevant provider manual, and any other notices or directives issued by the Department. The

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provider must create and maintain documents to substantiate that all requirements are met. (See Section 2.6: Record Keeping of this manual chapter).

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

Supervision

Recognized Peer Supervisor (RPS) Eligibility Criteria

1. Minimum of 21 years of age;
2. Successfully complete an OBH approved RPS Training as evidenced by completion certificate;
3. Currently employed with the behavioral health service provider agency; and
4. For RPS who are RPSS/CPSS, the following requirements must be completed annually:
 - a. Continuing education which includes ten (10) continuing education units (CEUs) in Peer Competencies (minimum of three units in Peer Supervisor Ethics annually) plus two (2) CEU hours in supervision annually. LMHPs who are RPS will comply with the CEUs of specified licensing board.

RPSS/CPSS must receive regularly scheduled clinical supervision from an RPS. The RPS must be either an LMHP or directly supervised by an LMHP. All LMHPs supervising RPSs are required to successfully complete a state approved Peer Supervisor Training. LMHP supervisors must have the practice-specific education, experience, training, credentials, and licensure to coordinate an array of behavioral health services. Supervision refers to treatment team support, guidance and consultation afforded to unlicensed staff rendering rehabilitation services, and shall not be confused with clinical supervision of bachelor’s or master’s level individuals pursuing licensure. Discussions during treatment planning and treatment team meetings between the RPS and RPSS/CPSS do not count as supervision.

1. Supervision must be provided by an RPS who has successfully completed an OBH approved peer recovery specialist supervisor training;

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2. Supervision must be provided in a culturally sensitive manner that represents the cultural needs and characteristics of the staff, the service area, and the population being served;
3. A full-time supervisor shall not supervise more than seven (7) full-time RPSS/CPSS. Supervisory staff time for part-time peer supervisors shall be at least proportionate to the ratio of one full-time supervisor to seven RPSS/CPSS;
4. RPSS/CPSS shall receive a minimum of:
 - a. **Four (4)** hours of supervision per month for full time RPSS/CPSS;
 - b. **Two (2)** hours of supervision per month for employees providing reimbursable services with member contact 21 to 32 hours per week; and
 - c. **One (1)** hour of supervision per month for employees providing reimbursable services with member contact less than 20 hours per week. Each month, the remaining hours of supervision may be in a group setting. Given consideration of case load and acuity, additional supervision may be indicated.
5. Group supervision means one RPS and not more than seven (7) supervisees in supervision session;
6. A maximum of 50 percent of the individual and group supervision may be telephonic or via a secure Health Insurance Portability and Accountability Act (HIPAA) compliant online synchronous videoconferencing platform. Remaining supervision hours shall be provided in face-to-face meetings between the supervisor and the RPSS/CPSS. Texts and/or emails cannot be used as a form of supervision to satisfy this requirement;
7. Supervision of the RPSS/CPSS shall include direct observation, assessment and feedback regarding the delivery of services, and teaching and monitoring of the application of recovery/resiliency and system of care principles and practices;
8. Non-licensed peer supervisors will consult with their LMHP peer supervisor within 24 hours of becoming aware of the issues and situations that may require clinical support;

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9. The RPS must ensure services are in compliance with the established and approved treatment plan;
10. The supervision with the RPS must:
 - a. 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); and
 - b. Progress notes that are discussed in supervision must have the RPS signature.
11. Supervision with the RPS must be documented. Documentation shall reflect the content of the training and/or treatment team guidance. The documentation must include the following:
 - a. Date and duration of supervision;
 - b. Identification of supervision type as individual or group supervision;
 - c. If the RPS is not an LMHP, then the name, licensure credentials, and signature of the LMHP supervisor must be provided;
 - d. Name and credentials (provisionally licensed, master’s degree, bachelor’s degree, or high school degree) of the supervisees;
 - e. Focus of the session and subsequent actions that the supervisee/s must take;
 - f. Date and signature of the RPS;
 - g. Date and signature of the supervisee/s;
 - h. Member identifier, service and date range of cases reviewed and/or PSS topics addressed; and
 - i. Start and end time of each supervision session.

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PSS must be provided under the administrative oversight of licensed and accredited local governing entities (LGEs) or OAAS certified PSH providers (as determined by LDH OAAS). LGEs and OAAS certified PSH provider agencies must meet state and federal requirements for providing PSS.

Agency

To provide PSS, agencies must meet the following requirements:

1. Licensed by the LDH per La. R.S. 40:2151 et seq.;
2. 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 compliance with all of the below:
 - a. La. R.S. 40:1203.1 *et seq.* associated with criminal background checks of un-licensed workers providing patient care;
 - b. La. R.S. 15:587, as applicable; and
 - c. Any other applicable state or federal law.
3. 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. Evidence of the individual passing the criminal background check requirements must be maintained on file with the provider agency;
4. The provider must review the Department of Health and Human Services (DHHS)' 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

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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 DHHS' 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 the DHHS' OIG;

5. Providers are required to maintain results 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;
6. Arranges for and maintains documentation that all RPSS/CPSS, prior to employment, are free from Tuberculosis (TB) in a communicable state via skin testing (or chest exam if recommended by physician) to reduce the risk of such infections in members and staff. Results from testing performed over thirty (30) days prior to date of employment will not be accepted as meeting this requirement;
7. Establishes and maintains written policies and procedures inclusive of drug testing staff to ensure an alcohol and drug-free workplace and a workforce free of substance use (See Appendix D);
8. Maintains documentation that all RPSS/CPSS providing direct care, who are required to complete first aid and cardiopulmonary resuscitation (CPR), complete American Heart Association (AHA) recognized training within ninety (90) days of hire, which shall be renewed within a time period recommended by the AHA (See Appendix D);
9. Maintains documentation of verification of completion of required trainings for all RPSS/CPSS staff;
10. Maintains documentation that all persons employed by the organization complete training in a state recognized Crisis Intervention curriculum prior to handling or managing crisis responses, which shall be updated annually. (See Appendix D for list of trainings); and
11. Has a National Provider Identifier (NPI), and must include the agency NPI number and the NPI number of the individual rendering PSS on its behalf on all claims for Medicaid reimbursement, where applicable.

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Staff

Individuals providing PSS must operate under the administrative oversight of a licensed and accredited LGE or an OAAS certified PSH provider agency.

RPSS/CPSS must meet the following qualifications:

1. Must have lived experience with a mental illness and/or substance use challenge, disorder, or condition;
2. Must be at least 21 years of age;
3. Must have a high school diploma or General Educational Development (GED);
4. Must successfully complete an LDH/OBH approved peer training program prior to providing PSS. Training must provide RPSS/CPSS with a basic set of competencies necessary to perform the peer support function. Successful completion requires obtaining the minimum qualifying score or better on required knowledge and skill assessments;
5. Individuals rendering PSS services must meet the following requirements:
 - a. Have the minimum qualifications of being at least 21 years of age;
 - b. Possess a high school diploma or GED;
 - c. Successfully completed the LDH/OBH approved training for RPSS/CPSS;
 - d. Received 25 hours of documented clinical Supervision in Core Competencies; and
 - e. Be in good standing with documenting and submitting annual CEUs.
6. Must be recognized by an OBH approved certification organization;
7. Must maintain and adhere to continuing education standards as defined in this manual chapter;
8. Must have at least twelve (12) months of continuous recovery, which is demonstrated by a lifestyle and decisions supporting an individual’s overall wellness and recovery. Through the Recovery Support Strategic Initiative, SAMHSA has delineated four major dimensions that support a life in recovery:

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- a. **Health** – Overcoming or managing one’s disease(s) or symptoms, and for everyone in recovery, making informed, healthy choices that support physical, mental, and emotional wellbeing;
 - b. **Home** – A stable and safe place to live;
 - c. **Purpose** – Meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society; and
 - d. **Community** - Relationships and social networks that provide support, friendship, love, and hope.
9. Must complete continuing education in confidentiality requirements, HIPAA requirements and mandated reporting;
 10. Must sign acknowledgement and receipt of Peer Support Specialist Code of Ethics;
 11. Satisfactory completion of criminal background checks pursuant to the, La R.S. 40:1203.1 *et seq.*, La R.S. 15:587 (as applicable), and any applicable state or federal law or regulation;
 12. Employees and contractors must not be excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the DHHS’ OIG;
 13. Employees and contractors must not have a finding on the Louisiana State Adverse Action List;
 14. Must pass a tuberculosis (TB) test prior to employment;
 15. Must pass drug screening tests as required by provider agency’s policies and procedures;
 16. Must complete AHA recognized First Aid and CPR training. Psychiatrists, Advanced Practice Registered Nurses (APRNs), Physician Assistants (PAs), Registered Nurses (RNs), and Licensed Practical Nurses (LPNs) are exempt from this training (See Appendix D); and
 17. Individuals providing PSS for the provider agency must have an NPI number which must be included on any claim submitted by that provider agency for reimbursement, when applicable.

Additional qualifications may be required by the agency employing the RPSS/CPSS. The employing agency must ensure that the RPSS/CPSS possesses the minimum requisite skills,

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qualifications, training, supervision, and coverage in accordance with the requirements described in the version of the Medicaid Behavioral Health Services Provider Manual effective on the date of service, State Plan amendments, and all applicable state and federal laws, regulations, and rules.

RPSS/CPSS Training

1. RPSS/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 SAMHSA, and has been approved by the OBH;
2. Training must provide the RPSS/CPSS with a basic set of competencies that complies with the core competencies of the profession to perform the peer support function. To achieve successful completion, the RPSS/CPSS must obtain the minimum qualifying score, or better, on the required knowledge and skill assessments;
3. The RPSS/CPSS is required to complete twenty-five (25) hours of documented Recovery Support Supervision in Core Competencies, with five (5) hours targeting each domain, prior to working independently. Additionally, mentoring from an RPS or LMHP clinical supervisor in the field is necessary before the RPSS/CPSS can work independently. The immediate supervisor of a RPSS/CPSS shall determine the need for additional supervision or mentoring, prior to allowing a RPSS/CPSS to work independently. Supervision must take place in a setting where behavioral health and/or recovery and crisis support services are being provided, and it must be provided by qualified supervisory staff, as outlined in the organization's job description;
4. The RPSS/CPSS must complete a minimum of ten (10) CEUs in the tenets of peer support approved by OBH per calendar year. Out of these, three (3) CEUs must be in the area of Ethics, while the remaining seven (7) will be in the principles and competencies related to tenets of peer support. Mandatory job training courses, such as blood borne pathogens, sexual harassment, or prohibited political activity, that are neither recovery oriented or related to Peer Support shall not be counted towards this continuing education requirement. Documentation of completion of the ten (10) approved CEUs must be submitted to OBH by December 31 each year; otherwise, the RPSS/CPSS will be considered lapsed. (See Appendix D); and

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5. Submission of annual attestation statement, as approved by LDH/OBH, indicating compliance with the Code of Ethics and Scope of Practice to OBH by December 31st of each year.

Allowed Provider Types and Specialties

1. PT 74 Mental Health Clinic PS 70 Clinic/Group PSS 8E Coordinated System of Care (CSoC)/Behavioral Health. (**NOTE:** Provider type to be only utilized by local governing entities (LGEs); and
2. PT 77 Mental Health Rehab PS 78 MHR. (**NOTE:** OAAS certified PSH providers must utilize the MHR provider type when providing peer support services, see the Provider Qualifications section above).

PT 74 Mental Health Clinic PS 70 Clinic/Group PSS 8E CSoC/ Behavioral Health.

Limitations/Exclusions

The following services shall be excluded from Medicaid coverage and reimbursement:

1. Services that are purely recreational, social or leisure in nature, or have no therapeutic or programmatic content;
2. PSS that are provided to members as an integral part of another covered Medicaid service;
3. Transportation;
4. General office/clerical tasks; and
5. Attendance in meetings or sessions without a documented purpose/benefit from the peer’s presence in that meeting or session.

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Personal Care Services

Personal care services (PCS) include assistance and/or supervision necessary for members with mental illness to enable them to accomplish routine tasks and live independently in their own homes.

Components

PCS include the following:

1. Minimal assistance with, supervision of, or prompting the member to perform **activities of daily living (ADLs)** including eating, bathing, grooming/personal hygiene, dressing, transferring, ambulation, and toileting;
2. Assistance with, or supervision of, **instrumental activities of daily living (IADLs)** to meet the direct needs of the member (and not the needs of the member's household), which includes:
 - a. Light housekeeping, including ensuring pathways are free from obstructions;
 - b. Laundry of the member's bedding and clothing, including ironing;
 - c. Food preparation and storage;
 - d. Assistance with scheduling (making contacts and coordinating) medical appointments;
 - e. Assistance with arranging transportation depending on the needs and preferences of the member;
 - f. Accompanying the member to medical and behavioral health appointments and providing assistance throughout the appointment;
 - g. Accompanying the member to community activities and providing assistance throughout the activity;

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- h. Brief occasional trips outside the home by the direct service worker (DSW) on behalf of the member (without the member present) to include shopping to meet the health care or nutritional needs of the member or payment of bills if no other arrangements are possible and/or the member’s condition significantly limits participation in these activities; and
- i. Medication reminders with self-administered prescription and non-prescription medication that is limited to:
 - i. Verbal reminders;
 - ii. Assistance with opening the bottle or bubble pack when requested by the member;
 - iii. Reading the directions from the label;
 - iv. Checking the dosage according to the label directions; or
 - v. Assistance with ordering medication from the drug store.

NOTE: PCS workers are NOT permitted to give medication to members. This includes taking medication out of the bottle to set up pill organizers.

- 3. Assistance with performing basic therapeutic physical health interventions to increase functional abilities for maximum independence in performing activities of daily living, such as range of motion exercise, as instructed by licensed physical or occupational therapists, or by a registered nurse.

Eligibility Criteria

Medicaid eligible members who meet medical necessity criteria may receive PCS when recommended by the member’s treating licensed mental health professional (LMHP) or physician within their scope of practice. Members must be at least 21 years of age and have transitioned from a nursing facility or been diverted from nursing facility level of care through the My Choice Louisiana program. Members must be medically stable, not enrolled in or eligible for a Medicaid-funded program which offers a personal care service or related benefit, including Long Term

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Personal Care Services (LT-PCS), and whose care needs do not exceed that which can be provided under the scope and/or service limitations of this personal care service.

Service Utilization

Services require prior authorization. Providers shall submit sufficient documentation to determine medical necessity. Failure to do so may result in a partial or non-authorization for services.

Services are limited to 20 hours per week. An exception may be made by the MCO Medical Director to exceed this limit with documentation that services are medically necessary and the member does not qualify for PCS under another Medicaid-funded program.

The weekly limit does not include the per diem rate, which is to be used for temporary, time-limited events in which a member may need additional assistance, such as following a member’s hospitalization. The per diem rate shall not exceed 30 calendar days in a one-year period.

Service Delivery

There shall be member involvement throughout the planning and delivery of services. Services shall be:

1. Delivered in a culturally and linguistically competent manner in accordance with member’s preferences and needs;
2. Respectful of the member receiving services;
3. Appropriate to members of diverse racial, ethnic, religious, sexual and gender identities and other cultural and linguistic groups; and
4. Appropriate for age, development, and education.

Allowed Mode(s) of Delivery

Individual.

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Provider Responsibilities

1. Report any changes in the member’s condition or behavior that impact the member’s health and safety to the appropriate MCO and if applicable, the community case manager;
2. Participate in team meetings as requested by the member’s case manager;
3. Providers must abide by all staffing and training requirements and ensure that staff and supervisors possess the minimum requisite education, skills, qualifications, training, supervision, and coverage as set forth by their respective licensing authorities and in accordance with all applicable Louisiana Department of Health (LDH) policies;
4. Providers shall conduct self-audits, including conducting home visits, to ensure staff follow internal policies and procedures, and comply with service requirements established by LDH;
5. Utilize the LDH-designated electronic visit verification system (EVV) to “check in” and “check out” when DSWs begin and end service delivery for a member in accordance with LDH-established EVV policies and procedures. The policies and procedures may be accessed at <https://ldh.la.gov/page/3819>;

Providers shall have available computer equipment, software, and internet connectivity necessary to participate in required prior/post authorization, data collection, and electronic visit verification activities.

6. Providers shall not refuse to serve any member who chooses their agency, unless there is documentation to support an inability to meet the member’s needs, or all previous efforts to provide service and supports have failed and there is no option but to refuse services. LDH and the managed care entity must be notified immediately of the circumstances surrounding the refusal. The refusal request must be made in writing by the provider to LDH, or its designee, and to the member detailing why the provider is unable to serve the member. This requirement may only be waived by LDH or its designee;

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7. Providers shall have the capacity and resources to provide all aspects of any service they are enrolled to provide in the specified service area;

8. If the provider proposes involuntary transfer, discharge of a member, or if a provider closes in accordance with licensing standards, the following steps must be taken:
 - a. The provider shall give written notice to the member, a family member and/or the authorized representative, if known, and the case manager, if applicable, at least 30 calendar days prior to the transfer or the discharge;

 - b. Written notice shall be made via certified mail, return receipt requested and shall be in a language and manner that the member understands;

 - c. A copy of the written discharge/transfer notice shall be put in the member’s record;

 - d. When the safety or health of members or provider staff is endangered, written notice shall be given as soon as possible before the transfer or discharge to the member, a family member and/or the authorized representative, if known, and the case manager; and

 - e. The written notice shall include the following:
 - i. A reason for the transfer or discharge;

 - ii. The effective date of the transfer or discharge;

 - iii. An explanation of a member’s right to personal and/or third parties’ representation at all stages of the transfer or discharge process;

 - iv. Contact information for the Advocacy Center;

 - v. Names of provider personnel available to assist the member and family in decision making and transfer arrangements;

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- vi. The date, time and place for the discharge planning conference;
 - vii. A statement regarding the member’s appeal rights;
 - viii. The name of the director, current address and telephone number of the Division of Administrative Law; and
 - ix. A statement regarding the member’s right to remain with the provider and not be transferred or discharged if an appeal is timely filed.
9. Provider transfer or discharge responsibilities shall include:
- a. Holding a transfer or discharge planning conference with the member, family, case manager (if applicable), legal representative and advocate, if such is known;
 - b. Developing discharge options that will provide reasonable assurance that the member will be transferred or discharge to a setting that can be expected to meet their needs;
 - c. Preparing an updated service plan, as applicable, and preparing a written discharge summary that shall include, at a minimum, a summary of the health, behavioral issues, social issues and nutritional status of the member; and
 - d. Providing all services required prior to discharge that are contained in the final update of the service plan, as applicable, and in the transfer or discharge plan.

Service Documentation

Providers must develop a service plan in collaboration with the member/member’s family to include the specific activities to be performed, including frequency and anticipated/estimated duration of each activity, based on the member’s goals, preferences, and assessed needs. The service plan must be developed prior to service delivery and updated at least every six (6) months, or more frequently based on changes to the member’s needs or preferences. The PCS provider shall provide the plan to the member prior to service delivery and when the plan is updated.

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Service Logs

Service logs document the PCS provided and billed. These service logs are the “paper trail” for services delivered by the DSW.

DSWs must complete a standardized service log at each visit to reflect services provided, and variations from the approved service plan and reason. The service log must also contain:

1. Name of the member;
2. Name of provider and DSW provider the service;
3. Assistance provided;
4. Date of service contact; and
5. Place of service.

Service logs must be:

1. Completed daily as tasks are performed (service logs may not be completed prior to the performance of a task); and
2. Signed and dated by the DSW and by the member or responsible representative after the work has been completed at the end of the week.

A separate log must be kept for each member. All portions of the service log must be completed each week.

In addition, DSWs and providers must document services provided through the electronic visit verification system, in accordance with Section X.

Back-Up Staffing & Emergency Evacuation Plans

PCS providers must develop a back-up staffing plan in the event the assigned DSW is unable to provide support due to unplanned circumstances or emergencies that may arise during the DSW’s shift. PCS providers must discuss available options for back-up coverage with the member or their authorized representative and complete the required staffing plan. The plan must include:

1. Person or persons responsible for back up coverage (including names, relationships,

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and contact phone numbers);

2. A toll-free telephone number with 24-hour availability that allows the recipient to contact the provider if the worker fails to show up for work; and
3. Provider and member signatures and dates.

In all instances when a DSW is unable to provide support, they must contact the provider and family/member immediately. Actions shall then be taken according to the member’s back-up staffing plan. PCS providers must assess on an ongoing basis whether the back-up plan is current and being followed according to the plan. The provider shall collaborate with the member, their authorized representative, case manager if applicable, and protective services if applicable to assure that any back-up staffing issues are resolved appropriately.

Providers must also ensure each member has a documented individualized emergency plan in preparation for, and response to, emergencies and disasters that may arise. This plan must identify specific resources available through the provider, natural resources, and the community. The provider must assess on an ongoing basis whether the emergency plan is current and being followed according to the plan. The emergency plan must be signed and dated by the member, authorized representative, and provider. If the emergency plan is activated, the provider bears responsibility for performance of those tasks agreed to in the plan.

The back-up staff plan and emergency plan must be provided to members and/or their authorized representative prior to delivering services and when the plan is updated.

Provider Qualifications

Agency

The PCS provider agency must:

1. Be licensed by LDH as a Home and Community Based Service provider/Personal Care Attendant agency per Revised Statute 40:2120.1 et seq. and LAC 48:I. Chapter 50;
2. Arrange for and maintain 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

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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. Criminal background checks performed over 30 days prior to date of employment will not be accepted as meeting this requirement;

3. Arrange for and maintain documentation that all persons, prior to employment, are free from TB in a communicable state as defined by the LAC 51:II.Chapter 5 to reduce the risk of such infections in recipients and staff. Results from testing performed over 30 days prior to date of employment will not be accepted as meeting this requirement;
4. Establish and maintain written policies and procedures inclusive of drug testing staff to ensure an alcohol and drug-free workplace and a workforce free of substance use (See Appendix D);
5. Maintain documentation that all direct care staff, who are required to complete First Aid and CPR training, complete a training with a curriculum based on guidelines published by the American Heart Association (AHA) within 90 days of hire, which shall be renewed within a time period recommended by the AHA (See Appendix D);
6. 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:
 - a. 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

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Medicare Program by Louisiana Medicaid or the Department of Health and Human Services’ Office of Inspector General; and

- b. 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>.
- 7. Ensure and maintain documentation that all unlicensed persons employed by the organization complete a documented training in a recognized Crisis Intervention curriculum prior to handling or managing crisis responses, which shall be updated annually; and
- 8. Maintain documentation of verification of completion of required trainings for all staff.

Staff

Direct care staff must meet the following individual qualifications:

- 1. Be at least 18 years of age;
- 2. Have a high school diploma, general equivalency diploma or trade school diploma in the area of human services (See Appendix B.), or demonstrate competency or verifiable work experience in providing support to persons with disabilities;
- 3. Pass criminal and professional background checks through the Louisiana Department of Public Safety, State Police prior to employment;
- 4. Pass a TB test prior to employment in accordance with the LAC 51:II.Chapter 5; OR be free from Tuberculosis (TB) in a communicable state as defined by the LAC 51:II.Chapter 5;
- 5. Pass drug screen testing as required by agency’s policies and procedures;
- 6. Complete a basic clinical competency training program approved by OBH prior to providing services. Psychiatrists and LMHPs are exempt from this training. (See Appendix D);

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7. Complete First Aid and CPR training with a curriculum based on guidelines published by the American Heart Association (AHA). Psychiatrists, APRNs/CNSs/PAs, RNs and LPNs are exempt from this training (See Appendix D);
8. Pass a motor vehicle screen;
9. 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;
10. Not have a finding on the Louisiana State Adverse Action List;
11. Possess and provide documentation of a valid social security number; and
12. Comply with law established by R.S. 40:2179 et seq. and R.S. 40:2120 et seq., and meet any additional qualifications established under Rules promulgated by LDH in association with these statutes.

Allowed Provider Types and Specialties

1. PT 24 Personal Care Attendant Agency:
 - a. PS 5A (PCS-LTC) or 5D (PCS-LTC/EPSDT); and
 - b. Provider Subspecialty 8E CSoC/Behavioral Health.
2. PT 24 Personal Care Attendant Agency, PS 8E CSoC/Behavioral Health.

Limitations/Exclusions

1. PCS does not include administration of medication; insertion and sterile irrigation of catheters; irrigation of any body cavities which require sterile procedures; complex wound care; or skilled nursing services as defined in the State Nurse Practice Act.

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2. Services must be provided in home and community-based settings, and may not be provided in the following settings:
 - a. In a home or property owned, operated, or controlled by an owner, operator, agent, or employee of a licensed provider of personal care services;
 - b. In the DSW’s home; and
 - c. In a nursing facility, Intermediate Care Facility for the Developmentally Disabled, Institute for Mental Disease, or other licensed congregate setting.
3. There shall be no duplication of services including the following:
 - a. PCS may not be provided while the member is attending or admitted to a program or setting that provides in-home assistance with ADLs or IADLs or while attending or admitted to a program or setting where such assistance is provided;
 - b. IADLs may not be performed in the member’s home when the member is absent from the home. Exceptions may be approved by the Medicaid managed care medical director on a case-by-case, time-limited basis; and
 - c. PCS may not be billed during the time the member has been admitted to a hospital, nursing home, or residential facility. Services may be provided and billed on the day the member is admitted to the hospital and following the member’s discharge.
4. PCS shall not supplant care provided by natural supports;
5. PCS does not include room and board, maintenance, upkeep, and/or improvement of the member’s or family’s residence;
6. PCS may not be provided outside the state of Louisiana unless a temporary exception has been approved by the Medicaid managed care entity;
7. DSWs may not work more than 16 hours in a 24-hour period; and

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8. The following individuals are prohibited from being reimbursed for providing services to a member:
 - a. Biological, legal or step first, second, third or fourth degree relatives;
 - b. First-degree relatives include parents, spouses, siblings, and children;
 - c. Second-degree relatives include grandparents, grandchildren, aunts, uncles, nephews, and nieces;
 - d. Third-degree relatives include great-grandparents, great-grandchildren, great aunts, great uncles, and first cousins;
 - e. Fourth-degree relatives include great-great grandparents, great-great grandchildren, and children of first cousins; and
 - f. Curator, tutor, legal guardian, authorized representative, and any individual who has power of attorney.

Billing

1. The service unit is 15 minutes and is reimbursed at a flat rate, with the exception of the per diem rate for which the unit is a per day rate. The per diem rate is to be used for temporary, time-limited events when the member needs additional assistance, such as following a member’s hospitalization. The per diem rate shall not exceed 30 calendar days in a one-year period;
2. Reimbursement for services may be withheld or denied if the provider fails to use the EVV system or does not use the system in compliance with LDH’s policies and procedures for EVV; and
3. Transportation is not a required component of PCS although providers may choose to furnish transportation for members during the course of providing PCS. If transportation is furnished, the provider must accept all liability for their employee/DSW transporting a member. It is the responsibility of the provider to ensure the employee/DSW has a current, valid driver’s license, automobile liability insurance, and pass a motor vehicle screen prior to transporting members.

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Mental Health Rehabilitation Services

The following provisions apply to all mental health rehabilitation (MHR) services for children, adolescents and adults, which include the following:

1. Community Psychiatric Support and Treatment (CPST);
2. Psychosocial Rehabilitation; and
3. Crisis Intervention.

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 to promote the maximum reduction of symptoms and restoration to their best age-appropriate functional level.

Children and Adolescents

The expected outcome of rehabilitation services is restoration to a child/adolescent's best functional level by restoring the child/adolescent to their best developmental trajectory. This includes consideration of key developmental needs and protective factors such as:

1. Restoration of positive family/caregiver relationships;
2. Prosocial peer relationships;
3. Community connectedness/social belonging; and
4. The ability to function in a developmentally appropriate home, school, vocational and community settings.

Children/adolescents who are in need of specialized behavioral health services must be served within the context of the family to assure that family dynamics are addressed and are a primary part of the treatment plan and approach. While a child/adolescent is receiving rehabilitation services, a parent/caregiver and necessary family members should be involved in medically necessary services. The treatment plan and progress notes must indicate the member's parent/caregiver and family are involved in treatment.

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Where children have parents with terminated parental rights or situations where parental involvement is contraindicated, the legal guardian should be involved.

When clinically and developmentally appropriate (for instance, when providing services to an adolescent), services may be delivered without the parent/caregiver present, as long as the above standards of parent/caregiver involvement are met throughout treatment. However, particularly when services are delivered to younger children, the majority of the services should be delivered with parent/caregiver participating with the member as the services are delivered, as the most developmentally appropriate, clinically effective service will be delivered with the full engagement and participation of the parent/caregiver.

Following initial authorization, if a member is not progressing and the family is not engaged or participating in treatment, the treatment plan and approach should be updated to assure family involvement before reauthorization is considered.

Adults

The expected outcome for adults is to reduce the disability resulting from mental illness and assist in the recovery and resiliency of the individual. These services are home and community-based and are provided on an as needed basis to assist persons in coping with the symptoms of their illness. In order to meet the criteria for disability, one must exhibit impaired emotional, cognitive or behavioral functioning that is a result of mental illness. This impairment must substantially interfere with role, occupational and social functioning. The intent of rehabilitation services is to minimize the disabling effects on the individual's capacity for independent living, to prevent emergency department utilization and or limit the periods of inpatient treatment. The principles of recovery are the foundation for rehabilitation services. These services are intended for an individual with a mental health diagnosis only, a co-occurring diagnosis of mental health and substance use disorder or a co-occurring diagnosis of mental health and intellectual/developmental disability.

Rehabilitation services are expected to achieve the following outcomes:

1. Assist individuals in the stabilization of acute symptoms of illness;
2. Assist individuals in coping with the chronic symptoms of their illness;
3. Minimize the aspects of their illness which makes it difficult for persons to live independently;
4. Reduce or prevent psychiatric hospitalizations;

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5. Identify and develop strengths; and
6. Focus on recovery.

National Consensus Statement on Recovery – Recovery is a journey of healing and transformation enabling a person to live a meaningful life in a community of their choice while striving to achieve their full potential.

Ten components of recovery are as follows:

1. Self-Direction;
2. Individualized and Person Centered;
3. Empowerment;
4. Holistic;
5. Non-Linear;
6. Strengths-Based;
7. Peer Support;
8. Respect;
9. Responsibility; and
10. Hope.

Assessment for CPST and PSR

1. Each member must be assessed and must have a treatment plan developed based on that assessment;
2. Assessments must be performed by a licensed mental health provider LMHP, and for children and adolescents must be completed with the involvement of the primary caregiver;

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3. For adults, assessments must be performed prior to receiving CPST and/or PSR and at least once every 365 days until discharge. Assessments must also be performed any time there is a significant change to the member’s circumstances. See Appendix G-2 for vocational and employment considerations; and
4. For youth, assessments must be performed prior to receiving CPST and/or PSR and at least once every 180 days until discharge. Assessments must also be performed any time there is a significant change to the member’s circumstances. For additional details regarding conducting assessments for members 6 to 20 years of age, refer to Appendix G-1.

Treatment Plan Development for CPST and PSR

Treatment plans must be based on the member’s assessed needs and developed by an LMHP or physician in collaboration with direct care staff, the member, family and natural supports. The treatment plan must contain goals and interventions targeting areas of risk and need identified in the assessment. All team members, including the member and family, must sign the treatment plan. The member must 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 emergency department use or 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 include the following:

1. Goals and objectives that are specific, measurable, action oriented, realistic, and time-limited;
2. Specific interventions based on the assessed needs that must include reference to training material when delivering skills training;
3. Frequency and duration of services that will enable the member to meet the goals and outcomes identified in the treatment plan;
4. Services and interventions to support independent community living for transitioning adolescents and adults in the setting of their own choice and must support integration in the community, including opportunities to seek

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employment, engage in community life, control personal resources, and improve functional skills at school, home or in the community;

5. Member's strengths, capacities, and preferences;
6. 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 (See Appendix G.);
7. Place of service(s) for each intervention;
8. Staff type delivering each intervention;
9. Crisis avoidance interventions including the identification of risk factors and barriers with strategies to overcome them, including individualized back-up plans; and
10. Language written in a way that is clearly understandable by the member.

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 must 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.

Monitoring Member Progress

As a part of treatment planning, LMHPs must monitor progress with accomplishing goals and objectives. Progress may be measured by using one or more of the following methods that may include, but is not limited to:

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1. Assessing mental health symptoms; and
2. Assessing the member's level of improved functioning utilizing a variety of methods that may include ratings on standardized assessment tools, checklists, direct observation, role-play, self-report, improved grades, improved attendance at school or work, improved medication compliance, feedback from the member, family, teacher, and other stakeholders, and reduced psychiatric inpatient, emergency room, and/or residential utilization.

When it is determined that a member is making limited to no progress, the LMHP, in collaboration with the treatment team, member and family/caregiver, should update the treatment plan to increase the possibility that a member will make progress. If the member continues to make limited to no progress, the LMHP must consider if MHR services should continue or if a referral to a different level of service delivered by the same or a different provider may improve progress.

Documentation

The 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 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. 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 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 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.

Eligibility Criteria

All mental health services must be medically necessary in accordance with LAC 50:I.1101. The medical necessity for services must be determined by an LMHP or physician who is acting within the scope of their professional license and applicable state law. These rehabilitative services must be determined by and recommended by an LMHP or physician to promote the maximum reduction of symptoms and/or restoration of an individual to their best age-appropriate functional level.

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An adult with a diagnosis of a substance use disorder or intellectual/developmental disability without an additional co-occurring qualifying mental health diagnosis does 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)

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

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:

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

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. Providers must submit sufficient documentation to determine medical necessity. Failure to do so may result in a partial or non-authorization for services.

Services provided to children and adolescents must include communication and coordination with the family and/or legal guardian, including any agency legally responsible for the care or custody of the child. Coordination with other child-serving systems should occur, as needed, to achieve

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the treatment goals. All coordination must be documented in the child's/adolescent's medical record.

Determine the Appropriate Services and Level of Intensity

Prior to submitting an authorization request, the LMHP in collaboration with the member, family/caregiver, natural supports, and direct care staff must request services based on each member's assessment/reassessment, treatment history, treatment plan, progress toward accomplishing goals/objectives, level of member/family engagement, member choice/preference and level of need. The provider must ensure there is sufficient documentation to support the services requested.

The decision regarding the most effective interventions is based on a member's assessed needs, availability of treating providers in the member's geographic area, member preference, and other factors including a member's readiness for change and member/family level of engagement. Interventions recommended must not be limited to the services delivered by the provider or provider agency conducting the assessment and submitting the authorization request. The member's MCO conducting the authorization review may approve the requested service(s) or may recommend a more clinically appropriate service based on their review.

The intensity, frequency, and duration for any service must be individualized.

Service Delivery

There must be member involvement throughout the planning and delivery of services. Services must be:

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

Anyone providing mental health services must operate within their scope of practice license.

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Evidence-based practices require prior approval and fidelity review on an ongoing basis as determined necessary by the Department.

Active Intervention vs. Observation

Treatment is the active delivery of an intervention identified on a member's treatment plan. Passive observation of a member without an intervention is not a billable activity. For example, observing a member in school while in class, working on the job site, engaging in a recreational activity, interacting with peers, doing homework, or following directions from a teacher, coach, or principal is observation and is not considered an active billable intervention.

Service Location

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 must not be provided at an institute for mental disease (IMD) or secure settings (e.g. jails and prisons). The service location must be determined based on the member's treatment plan, the service delivered, and the participants involved. The service location or place of service must be documented on the member's treatment plan and must be associated with a specific goal or objective. The service location must be selected based on what is therapeutically appropriate and beneficial to the member.

For youth, providers should deliver services when the parent/caregivers are available. Services may be delivered at school or in a community location if appropriate for the service(s) delivered but should not be the primary location if delivered in isolation of the family/caregiver and natural support. The provider must document how the family is incorporated into the service being delivered outside of the home as the primary location.

The following are required when services are delivered at school:

1. The initial and ongoing assessment must indicate school related needs, which may include, but is not limited to, disruptive behaviors in school, poor school attendance, and difficulties with social and peer interactions in school;
2. Prior to MHR services being delivered in the school setting, each member must be assessed by an LMHP. This assessment must include a review of school records and interviews with school personnel. Ongoing reassessment of need must be

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conducted by an LMHP to determine if services must continue with school as a place of service;

3. MHR providers must collaborate with school personnel to collect data to monitor a member's progress. Data collection may include standardized tools as well as collecting other information to determine if a member is making progress. This must be documented in the member's record. Data collection is not billable;
4. The member must not be removed from a core class such as math, science, or English, without written permission from the parent and school personnel. A rationale must be documented in the member's record. If allowed by the member's school, direct interventions may be delivered in the classroom if medically necessary and on the member's treatment plan. Only observing a member is not billable;
5. Prior to delivering services in a member's school, the provider must obtain written approval from the school. The written approval must be filed in the member's record; and
6. Providers delivering services in a member's school must actively communicate and coordinate services with school personnel and with the member's family/caregiver to avoid service duplication.

Services in locations without the caregiver in attendance, such as school or community settings, must have written approval by the parent/caregiver filed in each member's record.

Providers must accurately identify and report on each claim where a service took place using the most appropriate CMS place of service code.

Delivering Services to Family Members

The agency owner or staff assigned to provide mental health services must not be a part of a member's family or a legal dependent. The family includes biological, legal or step first, second, third or fourth degree relatives. *Family member* means, with respect to an individual:

1. First-degree relatives include parents, spouses, siblings, and children;

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2. Second-degree relatives include grandparents, grandchildren, aunts, uncles, nephews, and nieces;
3. Third-degree relatives include great-grandparents, great-grandchildren, great aunts, great uncles, and first cousins; and
4. Fourth-degree relatives include great-great grandparents, great-great grandchildren, and children of first cousins.

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; and/or
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.

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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.

Provider Responsibilities

1. All services must be delivered in accordance with federal and state laws and regulations, the provider manual and other notices or directives issued by the Department. The provider must create and maintain documents to substantiate that all requirements are met. (See Section 2.6 of this manual chapter regarding record keeping);
2. 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;
3. Any licensed practitioner providing mental health services must operate within their scope of practice license; and
4. 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 must be limited to a maximum combined total of twelve (12) reimbursable hours of CPST services and PSR services within a calendar day:
 - a. The twelve-(12) hour limitation must not apply per individual behavioral health services provider agency, rather it applies per individual rendering provider;
 - b. The twelve-(12) hour limitation must not apply to evidence-based practices; and
 - c. 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:
 - i. 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;

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- ii. 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
- iii. The services are billed for crisis intervention.

Core Services

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

1. Assessment;
2. Orientation;
3. Treatment;
4. Client education;
5. Consultation with professionals;
6. Counseling services;
7. Referral;
8. Rehabilitation services;
9. Crisis mitigation services; and
10. 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

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department alone does not constitute crisis mitigation services and does not satisfy this BHSP requirement.

The BHSP's crisis mitigation plan must include the following:

1. Identify steps to take when a client suffers from a medical, psychiatric, medication or relapse crisis; and
2. 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 must have a written contract with the entity provided the crisis mitigation services.

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

Core Staffing

The BHSP must abide by the following minimum core staffing requirements. BHSPs must 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:

1. Medical Director/Clinical Director;
2. Administrator;
3. Clinical Supervisor; and
4. Nursing Staff.

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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 must have a Clinical Director in accordance with the Clinical Director description below.

The medical director has the following assigned responsibilities:

1. Ensures that necessary medical services are provided that meet the needs of the clients;
2. 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;
3. Directs the specific course of medical treatment for all clients;
4. Reviews reports of all medically related accidents/incidents occurring on the premises and identifies hazards to the administrator;
5. Participates in the development and implementation of policies and procedures for the delivery of services;
6. Periodically reviews delivery of services to ensure care meets the current standards of practice; and
7. 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:

1. Writes the admission and discharge orders;

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2. Writes and approves all prescription medication orders;
3. Develops, implements and provides education regarding the protocols for administering prescription and non-prescription medications on-site;
4. Provides consultative and on-call coverage to ensure the health and safety of clients; and
5. 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) must:

1. Be 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;
2. Have the following assigned responsibilities:
 - a. Ensures that the necessary services are provided to meet the needs of the clients;
 - b. 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;
 - c. Directs the course of clinical treatment for all clients;

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- d. Reviews reports of all accidents/incidents occurring on the premises and identifies hazards to the Administrator;
 - e. Participates in the development and implementation of policies and procedures for the delivery of services;
 - f. Periodically reviews delivery of services to ensure care meets the current standards of practice; and
 - g. Participates in the development of new programs and modifications.
3. Have the following responsibilities or designates the duties to a qualified practitioner:
- a. Provides consultative and on-call coverage to ensure the health and safety of clients; and
 - b. Collaborates with the client’s primary care physician and psychiatrist as needed for continuity of the client’s care.

Administrator

An administrator must:

- 1. Possess 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;
- 2. Be responsible for the on-site day to day operations of the BHSP and supervision of the overall BHSP’s operation; and
- 3. Not perform any programmatic duties and/or make clinical decisions unless licensed to do so.

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Clinical Supervisor

A clinical supervisor must:

1. Be a fully licensed LMHP that maintains a current and unrestricted license with its respective professional board or licensing authority in the state of Louisiana;
2. Be on duty and on call as needed;
3. Have a minimum of two years qualifying experience as an LMHP in the provision of services provided by the BHSP; and
4. Have the following responsibilities:
 - a. Provides supervision utilizing evidence-based techniques related to the practice of behavioral health counseling;
 - b. Serves as resource person for other professionals counseling or providing direct services to clients with behavioral health disorders;
 - c. Attends and participates in treatment planning activities and discharge planning;
 - d. Functions as client advocate in treatment decisions;
 - e. Ensures BHSP adheres to rules and regulations regarding all behavioral health treatment, such as group size, caseload and referrals; and
 - f. Assists the Medical Director with the development and implementation of policies and procedures.

Mental Health Supervisor

As required pursuant to La. R.S. 40:2162, et seq., a mental health supervisor who, for those BHSPs, which provide Community Psychiatric Support and Treatment Services (CPST) or Psychosocial Rehabilitation Services (PSR) must:

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1. Be a fully licensed physician, or currently licensed and in good standing in the state of Louisiana to practice within the scope of all applicable state laws, practice acts, and the individual's professional license, as one of the following:
 - a. Medical psychologist;
 - b. Licensed psychologist;
 - c. Licensed clinical social worker (LCSW);
 - d. Licensed professional counselor (LPC);
 - e. Licensed marriage and family therapist (LMFT); or
 - f. Licensed advanced practice registered nurse (APRN) 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.
2. Be employed by the BHSP for at least 35 (thirty-five) hours per week; and
3. Assist in the design and evaluation of treatment plans for PSR and CPST services.

Nursing Staff

Nursing staff must:

1. Provide nursing care and services under the direction of a registered nurse necessary to meet the needs of clients;
2. Have a valid current nursing license in the state of Louisiana; and
3. 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

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other document. When not provided directly by the BHSP, the provider must maintain written documentation of the arrangement.

Staff Supervision for Non-Licensed Staff

Provisionally Licensed Professional Counselor (PLPC), Provisionally Licensed Marriage and Family Therapist (PLMFT), Licensed Master Social Worker (LMSW), Certified Social Worker (CSW) or a psychology intern from an APA approved internship program delivering CPST and/or PSR, services must be under regularly scheduled supervision in accordance with requirements established by the practitioner's professional licensing board. Proof of the board approved supervision must be held by the MHR agency employing these staff. For the psychology intern, the supervisory plan is acceptable. In addition, these staff who only provide CPST or PSR must receive at least one hour per calendar month of personal supervision and training by the provider agency's mental health supervisor pursuant to La. R.S. 40:2162, et seq. and must be documented according to the requirements listed in numbers 2 and 3 below.

Non-licensed staff providing PSR (excluding psychology interns) must receive regularly scheduled supervision from a person meeting the qualifications of a psychiatrist or an LMHP (excluding Licensed Addiction Counselors (LACs)). Mental Health 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 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. A supervisor may act in the role of the provider agency's Clinical Supervisor if the individual is qualified to fulfill both roles.

Non-licensed staff providing CI (excluding psychology interns) must receive regularly scheduled supervision from a person meeting the qualifications of a psychiatrist or an LMHP (excluding Licensed Addiction Counselors (LACs)). Psychiatrist/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 psychiatrist/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. A psychiatrist/LMHP supervisor may act in the role of the provider agency's Clinical Supervisor if the individual is qualified to fulfill both roles.

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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 July 15, 2020, staff must 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 must 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 case load 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.

Texts and/or emails cannot be used as a form of supervision to satisfy this requirement. All protected health information discussed during supervision must be HIPAA compliant.

The supervision with the LMHP must:

1. 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);
2. Progress notes that are discussed in supervision must have the LMHP supervisor signature; and
3. Have documentation reflecting the content of the training and/or clinical guidance. The documentation must include the following:
 - a. Date and duration of supervision;
 - b. Identification of supervision type as individual or group supervision;
 - c. Name and licensure credentials of the LMHP supervisor;

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- d. Name and credentials (provisionally licensed, master’s degree, bachelor’s degree, or high school degree) of the supervisees;
- e. The focus of the session and subsequent actions that the supervisee must take;
- f. Date and signature of the LMHP supervisor;
- g. Date and signature of the supervisees;
- h. Member identifier, service and date range of cases reviewed; and
- i. Start and end time of each supervision session.

Limitations/Exclusions

The following services must be excluded from Medicaid coverage and reimbursement:

- 1. Components that are not provided to, or directed exclusively toward, the treatment of the Medicaid eligible individual;
- 2. Services provided at a work site, which are job-oriented and not directly related to the treatment of the member's needs;
- 3. These rehabilitation services must not duplicate any other Medicaid State Plan service or service otherwise available to the member at no cost; and
- 4. Any services or components in which the basic nature of which are to supplant housekeeping, homemaking, or basic services for the convenience of an individual receiving services.

The following activities are not considered CPST or PSR, including PSH, and are therefore not reimbursable:

- 1. Activities 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;

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2. Child care provided as a substitute for the parent or other individuals responsible for providing care and supervision;
3. Respite care;
4. Teaching job related skills (management of symptoms and appropriate work habits may be taught);
5. Vocational rehabilitation (vocational assessment, job development, job coaching); CPST and PSR can include services, such as interpersonal skills, anger management, etc.) that enable the beneficiary to function in the workplace;
6. Transportation;
7. Staff training;
8. Phone contacts including attempts to reach the member by telephone to schedule, confirm, or cancel appointments;
9. Staff supervision;
10. Completion of paper work when the member and/or their significant others are not present. Requiring members to be present only for documentation purposes is not reimbursable;
11. Team meetings and collaboration exclusively with staff employed or contracted by the provider where the member and/or their family/caregivers are not present;
12. Observation of the member (e.g. in the school setting or classroom);
13. Staff research on behalf of the member;
14. Providers may not set up summer camps and bill the time as a mental health rehabilitation service;

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15. All contacts by salaried professionals such as supervisors, administrators, human resources staff, receptionists, etc. that are included in the rate (including meetings, travel time, etc.), are considered indirect costs;
16. Contacts that are not medically necessary;
17. Covered services that have not been rendered;
18. Services rendered that are not in accordance with an approved authorization;
19. Interventions not identified in the member's treatment plan;
20. Services provided to children, spouse, parents, or siblings of the eligible member 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 member's treatment plan;
21. Services provided that are not within the provider's scope of practice;
22. Any art, movement, dance, or drama therapies; and
23. Any intervention or contact not documented.

Community Psychiatric Support and Treatment

Community Psychiatric Support and Treatment (CPST) is a goal-directed support and solution-focused intervention, which focuses on reducing the disability resulting from mental illness, restoring functional skills of daily living, building natural supports, and achieving identified person-centered goals or objectives as set forth in the individualized treatment plan. Services address the individualized mental health needs of the member. Services are directed towards adults, children, and adolescents and will vary with respect to hours, type and intensity of services, depending on the changing needs of each individual. The purpose/intent of CPST services is to provide specific, measurable, and individualized services to each person served. CPST is not intended to be an indefinite, ongoing service. CPST is designed to provide rehabilitation services to individuals who can benefit from off-site rehabilitation or who have not been previously engaged in services, including those who had only partially benefited from traditional treatment. CPST services should be focused on the individual's ability to succeed in the community; to identify and access needed services; and to show improvement in school, work and family

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function. CPST is a face-to-face intervention with the individual present; however, family or other collaterals may also be involved. Most contacts occur in community locations where the person lives, works, attends school and/or socializes. Services must be provided in locations that meet the needs of the persons served.

Components Performed by an LMHP

1. **Initial and annual assessment**, including the LOCUS/CALOCUS; and
2. **Development of a treatment plan** in collaboration with the member and family if applicable (or other collateral contacts) on the specific strengths and needs, resources, natural supports and individual goals and objectives for the member. The overarching focus is to utilize the personal strengths, resources, and natural supports to reduce functional deficits associated with their mental illness and increase restoration of independent functioning. The treatment plan must include developing a crisis management plan.

Components Performed by an LMHP or other qualified professional (see staff qualifications)

1. **Ongoing monitoring of needs** including triggering an update of the treatment plan by the LMHP if needs change significantly;
2. **Counseling**, including mental health interventions that address symptoms, behaviors, thought processes, that assist the member in eliminating barriers to treatment and identifying triggers. Counseling includes assisting the member with effectively responding to or avoiding identified precursors or triggers that would impact the member's ability to remain in a natural community location. The use of evidenced based practices/strategies is encouraged; and
3. **Clinical psycho-education** includes using therapeutic interventions to provide information and support to better understand and cope with the illness. The illness is the object of treatment, not the family. The goal is for therapist, members, and families work together to support recovery, including assisting the individual and family members or other collaterals with identifying a potential psychiatric or personal crisis.

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CPST Allowed Provider Types and Specialties

1. PT 77 Mental Health Rehab PS 78 MHR
2. PT 74 Mental Health Clinic PS 70 Clinic / Group PSS 8E CSoC/ Behavioral Health

CPST Allowed Mode(s) of Delivery

1. Individual;
2. On-site; and
3. Off-site.

CPST Additional Service Criteria

Research-based and evidence-based practices (EBPs) may be billed using a combination of codes for licensed practitioners and, CPST, and are subject to prior authorization. The EBPs must be consistent with the CPST State Plan definition.

CPST Staff Ratio(s)

Caseload size must be based on the needs of the members/families, with an emphasis on successful outcomes and individual satisfaction and must meet the needs identified in the individual treatment plan.

CPST Provider Qualifications

Agency

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

1. Licensed – pursuant to La. R.S. 40:2151, *et seq.*;
2. 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. in writing within

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twenty-four (24) hours of receipt of notification to the managed care entities with which the agency contracts or is being reimbursed:

- a. All provider agencies regardless of when they were contracted with a Medicaid managed care entity 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; and
- b. 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 eighteen (18) months of the agency’s preliminary accreditation date and must 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).

- 3. 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:
 - a. 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;
 - b. La. R.S. 40:1203.1 *et seq.* associated with criminal background checks of un-licensed workers providing patient care;
 - c. La. R.S. 15:587, as applicable; and

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- d. Any other applicable state or federal law.

- 4. Providers must not hire individuals failing to meet criminal background check requirements and regulations. Individuals not in compliance with criminal background check requirements and regulations must 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;

- 5. 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;

NOTE: Providers are required to maintain results in personnel records that checks have been completed. The OIG maintains the LEIE on the OIG website and LDH maintains the Adverse Action website. (See Appendix A).

- 6. Establishes and maintains written policies and procedures inclusive of drug testing staff to ensure an alcohol and drug-free workplace and a workforce free of substance use. (See Appendix D);

- 7. Maintains documentation that all direct care staff, who are required to complete First Aid, cardiopulmonary resuscitation (CPR) and seizure assessment training, complete American Heart Association (AHA) recognized training within ninety (90) days of hire, which must be renewed within a time period recommended by the AHA. (See Appendix D);

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8. Maintains documentation of verification of completion of required trainings for all staff;
9. Ensures and maintains documentation that all non-licensed persons employed by the organization complete training in a recognized crisis intervention curriculum prior to handling or managing crisis responses, which must be updated annually;
10. 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; and
11. 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. Providers that meet the provisions of La. R.S. 40:2154.1

Providers that meet the provisions of La. R.S. 40:2154.1 must have submitted a completed license application by December 1, 2017, and must have become licensed by LDH Health Standards as a BHSP by April 1, 2018. Providers that submit a completed license application to LDH Health Standards by December 1, 2017, may continue to operate/provide services and may continue to participate in the Louisiana Medicaid Program during the pendency of the license application process (assuming that all other Medicaid requirements are met); however, such providers must receive a BHSP license issued by LDH Health Standards by April 1, 2018 in order to continue operation and in order to continue to participate in the Louisiana Medicaid Program and receive Medicaid payments.

Providers that meet one of applicability exemptions of La. R.S. 40:2154

Providers who meet one of applicability exemptions of the BHSP licensing statute, La. R.S. 40:2154, are required to obtain a BHSP license or other agency license issued by LDH Health Standards by April 1, 2018, in order to continue to participate in the Louisiana Medicaid Program and receive Medicaid payments. Such provider may continue to be reimbursed by Medicaid until April 1, 2018, provided that the provider complies with all other Medicaid requirements. Beginning April 1, 2018, if such provider does not have a BHSP license or other agency license issued by LDH Health Standards, the provider may no longer participate in the Louisiana Medicaid Program or receive Medicaid payments.

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Notwithstanding the above paragraph:

1. A licensed Home and Community-Based Service Provider may not perform CPST services unless it also has a BHSP license issued by LDH Health Standards; and
2. A school based health clinic/center or community mental health center may not perform CPST services unless it also has a BHSP license issued by LDH Health Standards.

Federally Qualified Health Centers

A federally qualified health center (FQHC) that provides CPST services under an agreement with a federal department/agency pursuant to federal law and regulation and pursuant to the provider’s approved scope of work for ambulatory services, is **NOT** required to obtain a BHSP license issued by LDH Health Standards; however, in this situation, the FQHC must only utilize practitioners approved via the Medicaid FQHC Provider Manual, i.e. psychiatrists, licensed clinical psychologists, and licensed clinical social workers, and must bill under its all-inclusive Prospective Payment System (PPS) rate and FQHC Medicaid provider number in accordance with the FQHC Medicaid Rules, policies, and manuals.

An FQHC that provides CPST services separate from an agreement with a federal department/agency pursuant to federal law and regulation and separate from its approved scope of work for ambulatory services, is required to obtain a BHSP license issued by LDH Health Standards. In this situation, the entity must enroll as an appropriate Specialized Behavioral Health Services (SBHS) provider type with a unique National Provider Identifier (NPI), must have active BHSP licensure issued by LDH Health Standards, and must bill under its unique BHSP NPI in accordance with the Behavioral Health Medicaid Rules, Policies, and Manuals.

Staff

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

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

1. Individuals rendering the assessment and treatment planning components of CPST services must be an LMHP.

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2. Effective January 1, 2023, individuals rendering all other components of CPST services must be an LMHP, Provisionally Licensed Professional Counselor (PLPC), Provisionally Licensed Marriage and Family Therapist (PLMFT), Licensed Master Social Worker (LMSW), Certified Social Worker (CSW) or a psychology intern from an APA approved internship program.

NOTE – STAFF OF EVIDENCE BASED PROGRAMS: It is LDH’s position that staff qualifications established by Act 503 of the 2022 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 must 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).

3. 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;
4. 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;
5. Direct care staff must not have a finding on the Louisiana State Adverse Action List;
6. Pass drug screening tests as required by agency’s policies and procedures.
7. Complete American Heart Association (AHA) recognized First Aid, CPR and seizure assessment training. Psychiatrists, APRNs/PAs, RNs and LPNs are exempt from this training. (See Appendix D); and

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8. 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.

Telehealth

For dates of service on or after May 1, 2023, telemedicine/telehealth is the use of a telecommunications system to render healthcare services when a physician, LMHP, or other qualified professional (see staff qualifications) and a member are not in the same location. Telehealth does NOT include the use of text, e-mail, or facsimile (fax) for the delivery of healthcare services.

The originating site means the location of the member at the time the telehealth services are provided. There is no restriction on the originating site and it can include, but is not limited to, a healthcare facility, school, or the member's home. Distant site means the site at which the physician or other licensed practitioner is located at the time the telehealth services are provided.

CPST may be provided via telecommunication technology when the following criteria is met:

1. The telecommunication system used by physicians, LMHPs and other qualified professional must be secure, ensure member confidentiality, and be compliant with the requirements of the Health Insurance Portability and Accountability Act (HIPAA);
2. The services provided are within the practitioner's telehealth scope of practice as dictated by the respective professional licensing board and accepted standards of clinical practice;
3. The member's record includes informed consent for services provided through the use of telehealth;
4. Services provided using telehealth must be identified on claims submission using by appending the modifier "95" to the applicable procedure code and indicating the correct place of service, either POS 02 (other than home) or 10 (home). Both the correct POS and the 95 modifier must be present on the claim to receive reimbursement;
5. Assessments and treatment planning conducted by an LMHP through telehealth shall include synchronous, interactive, real-time electronic communication

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comprising both audio and visual elements unless clinically appropriate and based on member consent; and

6. Providers must deliver in-person services when telehealth is not clinically appropriate or when the member prefers in-person services. The provider must document the member's preference for in-person or telehealth.

Psychosocial Rehabilitation

Psychosocial rehabilitation (PSR) services are designed to assist the individual with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their mental illness. Activities included must be intended to achieve the identified goals or objectives as set forth in the individual's individualized treatment plan. The intent of PSR is to restore the fullest possible integration of the individual as an active and productive member of their family, community and/or culture with the least amount of ongoing professional intervention. PSR is a face-to-face intervention with the individual present. Services may be provided individually or in a group setting. Most contacts occur in community locations where the person lives, works, attends school and/or socializes.

Psychosocial rehabilitation must be manualized or delivered in accordance with a nationally accepted protocol. PSR is directed toward a particular symptom and works on increasing or reducing a particular behavior.

Components

1. **Skills building** includes the practice and reinforcement of independent living skills, use of community resources and daily self-care routines. The primary focus is to increase the basic skills that promote independent functioning so the member can remain in a natural community location and achieve developmentally appropriate functioning, and assisting the member with effectively responding to or avoiding identified precursors or triggers that result in functional impairment.
2. **Supporting the restoration and rehabilitation of social and interpersonal skills** to increase community tenure, enhance personal relationships, establish support networks, increase community awareness, develop coping strategies and effective functioning in the individual's social environment, including home, work and school; and

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3. **Supporting the restoration and rehabilitation of daily living skills** to improve self-management of the negative effects of psychiatric or emotional symptoms that interfere with a person’s daily living. Supporting the individual with development and implementation of daily living skills and daily routines necessary to remain in home, school, work and community.

PSR Allowed Provider Types and Specialties

1. PT 77 Mental Health Rehab PS 78 MHR
2. PT 74 Mental Health Clinic PS 70 Clinic / Group PSS 8E CSoC/ Behavioral Health

PSR Allowed Mode(s) of Delivery

1. Individual;
2. Group;
3. On-site; and
4. Off-site.

PSR Staff Ratio(s)

The maximum group sizes are as follows:

1. One Full Time Employee (FTE) to fifteen (15) consumers is maximum group size for adults; and
2. One FTE to eight (8) consumers is maximum group size for youth.

PSR Provider Qualifications

Agency

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

1. Be licensed pursuant to La. R.S. 40:2151, *et seq.*;

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2. Be 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. in writing within twenty-four (24) hours of receipt of 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.

All provider agencies regardless of when they were contracted with a Medicaid managed care entity 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 eighteen (18) months of the agency’s preliminary accreditation date and must 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).

3. 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:
 - a. 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;
 - b. La. R.S. 40:1203.1 *et seq.* associated with criminal background checks of un-licensed workers providing patient care;

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- c. La. R.S. 15:587, as applicable; and
 - d. Any other applicable state or federal law.
- 4. Providers must not hire individuals failing to meet criminal background check requirements and regulations. Individuals not in compliance with criminal background check requirements and regulations must 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;
- 5. 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 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;

NOTE: Providers are required to maintain results in personnel records that checks have been completed. The OIG maintains the LEIE on the OIG website and LDH maintains the Adverse Action website. (See Appendix A).

- 6. Establishes and maintains written policies and procedures inclusive of drug testing staff to ensure an alcohol and drug-free workplace and a workforce free of substance use. (See Appendix D);
- 7. Maintains documentation that all direct care staff, who are required to complete First Aid, cardiopulmonary resuscitation (CPR) and seizure assessment training, complete American Heart Association (AHA) recognized training within ninety

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- (90) days of hire, which must be renewed within a time period recommended by the AHA. (See Appendix D);
8. Maintains documentation of verification of completion of required trainings for all staff;
 9. Ensures and maintains documentation that all non-licensed persons employed by the organization complete training in a recognized crisis intervention curriculum prior to handling or managing crisis responses, which must be updated annually;
 10. 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; and
 11. 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.

Providers that meet the provisions of La. R.S. 40:2154.1

Providers that meet the provisions of La. R.S. 40:2154.1 must have submitted a completed license application by December 1, 2017, and must have become licensed by LDH Health Standards as a BHSP by April 1, 2018. Providers that submit a completed license application to LDH Health Standards by December 1, 2017, may continue to operate/provide services and may continue to participate in the Louisiana Medicaid Program during the pendency of the license application process (assuming that all other Medicaid requirements are met); however, such providers must receive a BHSP license issued by LDH Health Standards by April 1, 2018 in order to continue operation and in order to continue to participate in the Louisiana Medicaid Program and receive Medicaid payments.

Providers that meet one of the applicability exemptions of La. R.S. 40:2154

Providers who meet one of applicability exemptions of the BHSP licensing statute, La. R.S. 40:2154, are required to obtain a BHSP license or other agency license issued by LDH Health Standards by April 1, 2018, in order to continue to participate in the Louisiana Medicaid Program and receive Medicaid payments. Such provider may continue to be reimbursed by Medicaid until April 1, 2018, provided that the provider complies with all other Medicaid requirements. Beginning April 1, 2018, if such provider does not have a BHSP license or other agency license

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issued by LDH Health Standards, the provider may no longer participate in the Louisiana Medicaid Program or receive Medicaid payments.

Notwithstanding the above paragraph:

1. A licensed Home and Community-Based Service provider may not perform PSR services unless it also has a BHSP license issued by LDH Health Standards; and
2. A school based health clinic/center or community mental health center may not perform PSR services unless it also has a BHSP license issued by LDH Health Standards.

Federally Qualified Health Centers

A federally qualified health center (FQHC) that provides psychosocial rehabilitation services under an agreement with a federal department/agency pursuant to federal law and regulation and pursuant to the provider’s approved scope of work for ambulatory services, is **NOT** required to obtain a BHSP license issued by LDH Health Standards; however, in this situation, the FQHC must only utilize practitioners approved via the Medicaid FQHC Provider Manual, i.e. psychiatrists, licensed clinical psychologists, and licensed clinical social workers, and must bill under its all-inclusive Prospective Payment System (PPS) rate and FQHC Medicaid provider number in accordance with the FQHC Medicaid Rules, policies, and manuals.

An FQHC that provides psychosocial rehabilitation services separate from an agreement with a federal department/agency pursuant to federal law and regulation and separate from its approved scope of work for ambulatory services, is required to obtain a BHSP license issued by LDH Health Standards. In this situation, the entity must enroll as an appropriate SBHS provider type with a unique National Provider Identifier (NPI), must have active BHSP licensure issued by LDH Health Standards, and must bill under its unique BHSP NPI in accordance with the Behavioral Health Medicaid Rules, Policies, and Manuals.

Staff

Staff must 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. Any individual rendering PSR services for a licensed and accredited provider agency must meet the following qualifications:

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- 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, criminal justice, 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.

NOTE: Services provided by staff meeting the minimum bachelor’s degree requirement may be billed at the master’s level if the individual’s master’s degree is received from an accredited university or college in any field.

- 2. 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;
- 3. 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;
- 4. Direct care staff must not have a finding on the Louisiana State Adverse Action List;
- 5. Pass drug screening tests as required by agency’s policies and procedures;
- 6. Complete American Heart Association (AHA) recognized First Aid, CPR and seizure assessment training. Psychiatrists, APRNs/PAs, RNs and LPNs are exempt from this training. (See Appendix D);
- 7. Non-licensed direct care staff are required to complete a basic clinical competency training program approved by the Office of Behavioral Health (OBH) prior to providing the service. (See Appendix D); and

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8. 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.

Crisis Intervention

Crisis intervention (CI) services are provided to a person who is experiencing a psychiatric crisis and are designed to interrupt and/or ameliorate a crisis experience, through a preliminary assessment, immediate crisis resolution and de-escalation and referral and linkage to appropriate community services to avoid more restrictive levels of treatment. The goals of CIs are symptom reduction, stabilization and restoration to a previous level of functioning. All activities must occur within the context of a potential or actual psychiatric crisis. CI is a face-to-face intervention and can occur in a variety of locations, including an emergency room or clinic setting, in addition to other community locations where the person lives, works, attends school and/or socializes.

Components

The components of Crisis Intervention services are as follows:

1. A preliminary assessment of risk, mental status and medical stability and the need for further evaluation or other mental health services must be conducted. This includes contact with the member, family members or other collateral sources (e.g., caregiver, school personnel) with pertinent information for the purpose of a preliminary assessment and/or referral to other alternative mental health services at an appropriate level;
2. Short-term CIs, including crisis resolution and debriefing with the identified Medicaid-eligible individual;
3. Follow up with the individual and, as necessary, with the individuals' caretaker and/or family members; and
4. Consultation with a physician or with other qualified providers to assist with the individuals' specific crisis.

NOTE: The components above are required unless the member is not available due to incarceration, hospitalization, or other unavoidable reason.

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CI Eligibility Criteria

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

All individuals who self-identify as experiencing a seriously acute psychological/emotional change, which results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved to effectively resolve it, are eligible.

CI Service Utilization

CI –Emergent is allowed without the requirement of a prior authorization in order to address the emergent issues in a timely manner. Additional units may be approved with prior authorization;

CI – Ongoing is authorized until the current crisis is resolved. The individual’s treatment record must reflect resolution of the crisis, which marks the end of the current episode;

The assessment of risk, mental status and medical stability must be completed by an LMHP with experience regarding this specialized mental health service, practicing within the scope of their professional license; and

The time spent by the LMHP during face-to-face time with the member is billed separately using CPT codes. This would include the assessment of risk; mental status and medical stability must be completed by the LMHP, choosing the code that best describes the care provided.

CI Allowed Provider Types and Specialties

1. PT 77 Mental Health Rehab PS 78 MHR
2. PT 74 Mental Health Clinic PS 70 Clinic / Group PSS 8E CSoC/ Behavioral Health

CI Allowed Mode(s) of Delivery

1. Individual;
2. On-site; and
3. Off-site.

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CI Additional Service Criteria

An individual in crisis may be represented by a family member or other collateral contact that has knowledge of the individual's capabilities and functioning. Individuals in crisis who require this service may be using substances during the crisis, and this will not, in and of itself, disqualify them for eligibility for the service.

Substance use should be recognized and addressed in an integrated fashion, as it may add to the risk, increasing the need for engagement in care.

The crisis plan developed by the non-licensed professional, in collaboration with the treatment team and LMHP, must be provided under the supervision of an LMHP with experience regarding this specialized mental health service. The LMHP must be available at all times to provide back up, support and/or consultation from assessment of risk and through all services delivered during a crisis.

CI Provider Qualifications**Agency**

To provide crisis intervention services, the agency must meet the following requirements:

1. Be licensed pursuant to La. R.S. 40:2151, *et seq.*;
2. Be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or The Joint Commission (TJC). Denial, loss of, or any negative change in accreditation status must be reported in writing immediately upon notification to the managed care entities with which the agency contracts or is being reimbursed;

NOTE: Agencies must apply for accreditation and pay accreditation fees prior to being contracted and reimbursed by a Medicaid managed care entity, and must maintain proof of accreditation application and fee payment. Agencies must attain full accreditation within eighteen (18) months of the initial accreditation application date.

3. 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 law and regulations below:

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- a. 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;
 - b. La. R.S. 40:1203.1 *et seq.* associated with criminal background checks of un-licensed workers providing patient care;
 - c. La. R.S. 15:587, as applicable; and
 - d. Any other applicable state or federal law.
5. Providers must not hire individuals failing to meet criminal background check requirements and regulations. Individuals not in compliance with criminal background check requirements and regulations must 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;
6. Providers 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 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;

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NOTE: Providers are required to maintain results in personnel records that checks have been completed. The OIG maintains the LEIE on the OIG website and LDH maintains the Adverse Action website. (See Appendix A).

7. Establishes and maintains written policies and procedures inclusive of drug testing staff to ensure an alcohol and drug-free workplace and a workforce free of substance use. (See Appendix D);
8. Maintains documentation that all direct care staff, who are required to complete First Aid, cardiopulmonary resuscitation (CPR) and seizure assessment training, complete American Heart Association (AHA) recognized training within ninety (90) days of hire, which must be renewed within a time period recommended by the AHA. (See Appendix D);
9. Maintains documentation of verification of completion of required trainings for all staff; and
10. Ensures and maintains documentation that all non-licensed persons employed by the organization complete training in a recognized Crisis Intervention curriculum prior to handling or managing crisis responses, which must be updated annually.

Providers that meet the provisions of La. R.S. 40:2154.1

Providers that meet the provisions of La. R.S. 40:2154.1 must have submitted a completed license application by December 1, 2017, and must have become licensed by LDH Health Standards as a BHSP by April 1, 2018. Providers that submit a completed license application to LDH Health Standards by December 1, 2017, may continue to operate/provide services and may continue to participate in the Louisiana Medicaid Program during the pendency of the license application process (assuming that all other Medicaid requirements are met); however, such providers must receive a BHSP license issued by LDH Health Standards by April 1, 2018 in order to continue operation and in order to continue to participate in the Louisiana Medicaid Program and receive Medicaid payments.

Providers that meet one of applicability exemptions of La. R.S. 40:2154

Providers who meet one of applicability exemptions of the BHSP licensing statute, La. R.S. 40:2154, are required to obtain a BHSP license or other agency license issued by LDH Health Standards by April 1, 2018, in order to continue to participate in the Louisiana Medicaid Program and receive Medicaid payments. Such provider may continue to be reimbursed by Medicaid until April 1, 2018, provided that the provider complies with all other Medicaid requirements.

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Beginning April 1, 2018, if such provider does not have a BHSP license or other agency license issued by LDH Health Standards, the provider may no longer participate in the Louisiana Medicaid Program or receive Medicaid payments.

Notwithstanding the above paragraph, the following also applies:

1. A licensed Home and Community-Based Service Provider may not perform CI services unless it also has a BHSP license issued by LDH Health Standards; and
2. A school based health clinic/center or community mental health center may not perform CI services unless it also has a BHSP license issued by LDH Health Standards.

Federally Qualified Health Centers

A federally qualified health center (FQHC) that provides crisis intervention services under an agreement with a federal department/agency pursuant to federal law and regulation and pursuant to the provider's approved scope of work for ambulatory services, is **NOT** required to obtain a BHSP license issued by LDH Health Standards; however, in this situation, the FQHC must only utilize practitioners approved via the Medicaid FQHC Provider Manual, i.e. psychiatrists, licensed clinical psychologists, and licensed clinical social workers, and must bill under its all-inclusive Prospective Payment System (PPS) rate and FQHC Medicaid provider number in accordance with the FQHC Medicaid Rules, policies, and manuals.

An FQHC that provides crisis intervention services separate from an agreement with a federal department/agency pursuant to federal law and regulation and separate from its approved scope of work for ambulatory services, **IS** required to obtain a BHSP license issued by LDH Health Standards. In this situation, the entity must enroll as an appropriate SBHS provider type with a unique National Provider Identifier (NPI), must have active BHSP licensure issued by LDH Health Standards, and must bill under its unique BHSP NPI in accordance with the Behavioral Health Medicaid Rules, Policies, and Manuals.

Staff

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

Staff must also meet the following requirements:

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1. Be at least 20 years old and have an associate's degree in social work, counseling, psychology or a related human services field or two years of equivalent education and/or experience working in the human services field. The Human Service field is defined as an academic program with a curriculum content in which at least 70 percent of the required courses are in the study of behavioral health or human behavior. Additionally, the staff must be at least three years older than an individual under the age of eighteen (18).

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 percent 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 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.

2. 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;
3. 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;
4. Direct care staff must not have a finding on the Louisiana State Adverse Action List;
5. Pass drug screening tests as required by agency's policies and procedures;
6. Complete American Heart Association (AHA) recognized First Aid, CPR and seizure assessment training. Psychiatrists, APRNs/ PAs, RNs and LPNs are exempt from this training. (See Appendix D);

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7. Non-licensed direct care staff are required to complete a basic clinical competency training program approved by OBH prior to providing the service. (See Appendix D); and
8. Complete a recognized crisis intervention training.

Addiction Services

Addiction services include an array of individual-centered outpatient, intensive outpatient, residential, and inpatient services consistent with the individual’s assessed treatment needs with a rehabilitation and recovery focus designed to promote skills for coping with and managing substance use symptoms and behaviors. These services are designed to help individuals achieve recovery. Services should address major lifestyle, attitudinal and behavioral problems that have the potential to be barriers to the goals of treatment.

The goals of substance use disorders prevention and treatment services for adolescents and adults are to acquire a responsive system of service delivery designed to respond to the needs of individuals by utilizing evidence-based models of care and provide the full continuum of care to meet the treatment needs of individuals within the community. The expected outcomes of receiving treatment are to return people to productive levels of functioning within their family, workplace, and community. The provision of treatment services is based on the belief that treatment is:

1. Effective;
2. Prevention works; and
3. People can and do recover from substance use disorders.

The most effective service delivery system is both member and family-centered, outcome driven and cost effective, allowing individuals and communities to utilize their strengths and resources to effectively respond to substance use disorders. Treatment enables people to counteract the powerful disruptive effects of substance use on the brain, their behavior and to regain control of their life.

Recovery outcomes of substance use disorders include but are not limited to the following:

1. Long-term abstinence;
2. Improved quality of life;
3. Improved family relationships;
4. Decreased criminal justice involvement;

5. Improved physical health and wellness;
6. Increase or sustained employment/education; and
7. Stability in housing.

The following American Society of Addiction Medicine (ASAM) levels are covered services by the Louisiana Medicaid program. The service definition, program requirements, and provider requirements for each level will be detailed throughout the manual chapter.

ASAM Levels Covered

1. Level 1: Outpatient;
2. Level 2.1: Intensive outpatient treatment;
3. Level 2-WM: Ambulatory withdrawal management with extended on-site monitoring;
4. Level 3.1: Clinically managed low-intensity residential treatment-adolescent;
5. Level 3.1: Clinically managed low-intensity residential treatment-adults;
6. Level 3.2-WM: Clinically managed residential social withdrawal management – adolescent;
7. Level 3.-2WM: Clinically managed residential social withdrawal management – adults;
8. Level 3.3: Clinically managed population specific high intensity residential treatment-adult;
9. Level 3.5: Clinically managed medium intensity residential treatment – adolescent;
10. Level 3.5: Clinically managed high intensity residential treatment- adult;
11. Level 3.7: Medically monitored high intensity inpatient treatment-adult (residential setting);

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- 12. Level 3.7: Medically monitored intensive inpatient treatment – adolescent (PRTF) (Refer to the *Psychiatric Residential Treatment Facilities (PRTF)* Section for definition, qualifications, and requirements);
- 13. Level 3.7-WM: Medically monitored inpatient withdrawal management-adult (residential setting); and
- 14. Level 4-WM: Medically managed intensive inpatient withdrawal management (hospital) - (Refer to the sections of this manual chapter on inpatient and outpatient hospitals for definition, qualifications, and requirements).

Provider Qualifications

Agency

To provide ASAM level addiction services, agencies must meet the following requirements:

- 1. Licensed by the Louisiana Department of Health (LDH) per La. R.S. 40:2151 et seq.;
- 2. Residential substance use treatment facilities must be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or The Joint Commission (TJC). Denial, loss of, or any negative change in accreditation status must be reported in writing immediately upon notification to the managed care entities with which the agency contracts or is being reimbursed;

NOTE: Facilities must apply for accreditation and pay accreditation fees prior to being contracted 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.

- 3. Services must be provided under the supervision of a licensed mental health professional (LMHP) or physician who is acting within the scope of their professional license and applicable state law. (Refer to Appendices B and D for more information on LMHPs). The term ‘supervision’ refers to clinical support, guidance and consultation afforded to unlicensed staff, and should not be confused with clinical supervision of bachelor’s or master’s level individuals or provisionally

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licensed individuals pursuing licensure. Such individuals must comply with current, applicable scope of practice and supervisory requirements identified by their respective licensing boards;

4. Arrange for and maintain 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:
 - a. 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 unlicensed direct care staff;
 - b. La. R.S. 40:1203.1 et seq. associated with criminal background checks of un-licensed workers providing patient care;
 - c. La. R.S. 15:587, as applicable; and
 - d. Any other applicable state or federal law.
5. Providers must not hire individuals failing to meet criminal background check requirements and regulations. Individuals not in compliance with criminal background check requirements and regulations must 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;
6. The provider must review the Department of Health and Human Services’ (DHHS’) 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

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Medicaid or the DHHS’ OIG. 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;

7. 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>;
8. Establish and maintain written policies and procedures inclusive of drug testing staff to ensure an alcohol and drug-free workplace and a workforce free of substance use. (Refer to Appendix D);
9. Maintain documentation that all direct care staff, who are required to complete First Aid, cardiopulmonary resuscitation (CPR) and seizure assessment training, complete American Heart Association (AHA) recognized training within 90 days of hire, which must be renewed within a time period recommended by the AHA. (Refer to Appendices A and D);
10. Maintain documentation of verification of staff meeting educational and professional requirements, licensure (where applicable), as well as completion of required trainings for all staff; and
11. Ensure and maintain documentation that all unlicensed persons employed by the organization complete training in a recognized crisis intervention (CI) curriculum prior to handling or managing crisis calls, which must be updated annually.

Staff

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

1. Licensed and unlicensed professional staff must be at least 18 years of age, with a high school diploma or equivalent according to their areas of competence as

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determined by degree, required levels of experience as defined by State law and regulations and departmentally approved guidelines and certifications;

2. Staff must be at least three years older than any client served under 18 years of age. Licensed individual practitioners with no documentation of having provided addiction services prior to December 1, 2015, are required to demonstrate competency via the Alcohol and Drug Counselor (ADC) exam, the Advanced Alcohol and Drug Counselor (AADC) exam, or the Examination for Master Addictions Counselor (EMAC). Any licensed individual practitioner, who has documentation of providing addiction services prior to December 1, 2015, and within their scope of practice is exempt from (ADC, AADC, EMAC) testing requirements. Organizational agencies are required to obtain verification of competency (passing of accepted examinations) or exemption (prior work history/resume, employer letter). Licensed providers practicing independently must submit verification of competency or an exemption request (based on verified required work history) to the Coordinated System of Care (CSoC) contractor and/or managed care organizations (MCOs) with whom they credential and contract;
3. Staff can include the Office of Behavioral Health (OBH) credentialed peer support specialists who meet all other qualifications. A peer specialist is a recommended position at all ASAM levels of care. A peer specialist is a person with lived experience with behavioral health challenges, who is in active recovery and is trained to assist others in their own recovery. The peer specialist uses their own unique, life-altering experience in order to guide and support others who are in recovery. This refers to individuals recovering from substance use disorders. Peer specialist work in conjunction with highly trained and educated professionals. They fill a gap by providing support from the perspective of someone who has first-hand experience;
4. The provider is prohibited from knowingly employing or contracting with, or retaining the employment of or contract with, a member of the direct care staff who has an alcohol or drug offense, unless the employee or contractor has completed their court-ordered sentence, including community service, probation and/or parole and been sober per personal attestation for at least the last two years;
5. Satisfactory completion of criminal background checks 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;

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6. Pass a motor vehicle screen (if duties may involve driving or transporting members);
7. Pass drug screening tests as required by agency’s policies and procedures;
8. 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;
9. Direct care staff must not have a finding on the Louisiana State Adverse Action List;
10. Complete AHA recognized First Aid, CPR and seizure assessment training. Psychiatrists, advanced practical registered nurses (APRNs)/clinical nurse specialists (CNSs)/physician assistants (PAs), registered nurses (RNs) and licensed practical nurses (LPNs) are exempt from this training. (Refer to Appendix D); and
11. Non-licensed direct care staff are required to complete a basic clinical competency training program approved by OBH prior to providing the service. (Refer to Appendix D).

Staffing Requirements

Personnel must consist of professional and other support staff that are adequate to meet the needs of the individuals admitted to the facility.

Medical Director

The provider must ensure that its **medical director** is a licensed physician, who:

1. Is an addictionologist; or
2. Meets all of the following:
 - a. Is board-eligible or board-certified;
 - b. Has two years of qualifying experience in treating addictive disorders; and

- c. Maintains a consulting relationship with an addictionologist.

Clinical Supervisor

State regulations require supervision of unlicensed professionals by a **clinical supervisor** who, with the exception of opioid treatment programs:

- 1. Is an LMHP that maintains a current and unrestricted license with its respective professional board or licensing authority in the state of Louisiana;
- 2. Must be on duty and on call as needed;
- 3. Has two years of qualifying clinical experience as an LMHP in the provision of services provided by the provider; and
- 4. Must have the following responsibilities:
 - a. Provide supervision utilizing evidenced-based techniques related to the practice of behavioral health counseling;
 - b. Serve as resource person for other professionals counseling persons with behavioral health disorders;
 - c. Attend and participate in care conferences, treatment planning activities, and discharge planning;
 - d. Provide oversight and supervision of such activities as recreation, art/music or vocational education;
 - e. Function as client advocate in treatment decisions;
 - f. Ensure the provider adheres to rules and regulations regarding all behavioral health treatment, such as group size, caseload, and referrals;
 - g. Provide only those services that are within the person’s scope of practice; and
 - h. Assist the clinical director and/or medical director and governing body with the development and implementation of policies and procedures.

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Licensed Mental Health Professional (LMHP)

LMHPs must comply with current, applicable scope of practice and supervisory requirements identified by their respective licensing boards. The LMHP providing addiction treatment services must have documented credentials, experience and/or training in working with clients who have addictive disorders, which must be maintained in the individual’s personnel record.

Unlicensed professionals (UPs)

UPs of addiction services must be registered with the Addictive Disorders Regulatory Authority (ADRA) and meet regulations and requirements in accordance with La. RS 37:3387 et seq. Written verification of ADRA registration must be maintained in the individual’s personnel record. Unlicensed staff who fall under a professional scope of behavioral health practice with formal board approved clinical supervision and whose scope includes the provision of addiction services will not need to register with ADRA. Unlicensed addiction providers must meet at least one of the following qualifications:

1. Be a master’s-prepared behavioral health professional that has not obtained full licensure privileges and is participating in ongoing professional supervision. When working in addiction treatment settings, the master’s-prepared UP must be supervised by an LMHP, who meets the requirements of this Section;
2. Be a registered addiction counselor;
3. Be a certified addiction counselor; or
4. Be a counselor-in-training (CIT) that is registered with ADRA and is currently participating in a supervision required by the Addictive Disorders practice act.

House Manager

A residential substance use provider must have a **house manager**. The house manager must:

1. Be at least 21 years old;
2. Have at least two years qualifying experience working for a provider that treats clients with mental illness and/or addictive disorders;
3. Supervise the activities of the facility when the professional staff is not on duty;

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4. Perform clinical duties only if licensed to do so;
5. Report allegations of abuse, neglect and misappropriation to the medical director;
6. Identify and respond to and report any crisis situation to the clinical supervisor when it occurs; and
7. Coordinate and consult with the clinical staff as needed.

Allowed Provider Types and Specialties

Outpatient Services

1. PT 68 Substance Use and Alcohol Use Center PS 70 Clinic/Group; and
2. PT 74 Mental Health Clinic PS 70 Clinic/Group.

Residential Services

1. PT AZ Substance Use Residential Treatment Facility PS 8U Substance Use or Addiction.

Eligibility Criteria

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

Adolescents are defined as children and youth, 0 through 20 years of age. Services may be provided up to the time the individual turns 21 years of age. An adult is defined as anyone 21 years of age and over.

Allowed Mode(s) of Delivery

1. Individual;
2. Group;

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- 3. On-site;
- 4. Off-site; and
- 5. Tele-video (LMHPs only).

Additional Service Criteria

A unit of service is defined according to the Health Care Financing Industry common procedure coding system (HCPCS) approved code set, unless otherwise specified. One session is equal to one visit.

These rehabilitation services are provided as part of a comprehensive specialized psychiatric program available to all Medicaid-eligible individuals with significant functional impairments resulting from an identified addiction diagnosis. Services are subject to prior approval, must be medically necessary and must be recommended by an LMHP or physician who is acting within the scope of their professional licensed and applicable State law to promote the maximum reduction of symptoms and/or restoration of an individual to their best age-appropriate functional level according to an individualized treatment plan.

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 (Refer to Section 2.6 – Record Keeping).

Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the youth’s medical record. Components that are not provided to, or directed exclusively toward the treatment of, the Medicaid-eligible individual are not eligible for Medicaid reimbursement.

Services provided at a work site must not be job tasks-oriented and must be directly related to treatment of an individual’s substance use needs. Any services or components of services, the basic nature of which are to supplant housekeeping, homemaking or basic services for the convenience of a person receiving covered services (including housekeeping, shopping, child-care and laundry services) are not covered.

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All substance use treatment services must offer the family component. Adolescent substance use programs must include family involvement, parent education and family therapy.

Room and board is excluded from any rates provided in a residential setting.

ASAM levels of care may be subject to prior approval and reviews on an ongoing basis to document compliance with the national standards.

Staffing for the facility must be consistent with State licensure regulations on a full-time employee (FTE) basis.

Adolescent facilities with greater than 16 beds must be a PRTF providing an inpatient level of care. Only facilities providing ASAM Level 3.7 will be permitted to become PRTFs.

For adults, independent lab work is not part of the capitated rate. However, routine drug screens that are part of residential, outpatient and inpatient services are covered under the rate paid to the provider.

Telehealth

Telemedicine/telehealth is the use of a telecommunications system to render healthcare services when a physician or LMHP and a member are not in the same location. Telehealth does NOT include the use of text, e-mail, or facsimile (fax) for the delivery of healthcare services.

The originating site means the location of the member at the time the telehealth services are provided. There is no restriction on the originating site and it can include, but is not limited to, a healthcare facility, school, or the member’s home. Distant site means the site at which the physician or other licensed practitioner is located at the time the telehealth services are provided. Assessments, evaluations, individual psychotherapy, family psychotherapy, and medication management services within intensive outpatient or outpatient treatment may be provided via telecommunication technology when the following criteria is met:

1. The telecommunication system used by physicians and LMHPs must be secure, ensure member confidentiality, and be compliant with the requirements of the Health Insurance Portability and Accountability Act (HIPAA);

2. The services provided are within the practitioner’s telehealth scope of practice as dictated by the respective professional licensing board and accepted standards of clinical practice;
3. The member’s record includes informed consent for services provided through the use of telehealth;
4. Services provided using telehealth must be identified on claims submission using by appending the modifier “95” to the applicable procedure code and indicating the correct place of service, either POS 02 (other than home) or 10 (home). Both the correct POS and the 95 modifier must be present on the claim to receive reimbursement;
5. Assessments and evaluations conducted by an LMHP through telehealth should include synchronous, interactive, real-time electronic communication comprising both audio and visual elements unless clinically appropriate and based on member consent; and
6. Providers must deliver in-person services when telehealth is not clinically appropriate or when the member requests in-person services.

Exclusions: Methadone admission visits conducted by the admitting physician within Opioid Treatment Programs are not allowed via telecommunication technology.

Alcohol and Drug Assessment and Referrals

Alcohol and drug assessment and referrals 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. 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 must comply with licensing standards and any further LDH standards outlined below in regard to assessment practices. Once an individual receives an assessment, a staff member must provide the individual with the identified clinical recommendation. Evaluations must include the consideration of appropriate psychopharmacotherapy. There must be evidence that the member was assessed to determine if Medication Assisted Treatment (MAT) was a viable option of care, based on the Substance Use Disorder (SUD) diagnosis.

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SUD providers, when clinically appropriate, must:

1. Educate members on the proven effectiveness, benefits and risks of Food and Drug Administration approved MAT options for their SUD;
2. Provide on-site MAT or refer to MAT offsite; and
3. Document member education, access to MAT and member response in the progress notes.

Residential SUD providers must 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 (all ASAM Levels)

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. The comprehensive bio-psychosocial evaluation must contain the following:

1. Circumstances leading to admission;
2. Past and present behavioral health concerns;
3. Past and present psychiatric and addictive disorders treatment;
4. Significant medical history and current health status;
5. Family and social history;
6. Current living situation;

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7. Relationships with family of origin, nuclear;
8. Family and significant others;
9. Education and vocational training;
10. Employment history and current status;
11. Military service history and current status;
12. Legal history and current legal status;
13. Emotional state and behavioral functioning, past and present; and
14. Strengths, weaknesses, and needs.

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 must be made.

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

Treatment plans must be based on the evaluations to include person-centered goal and objectives. The treatment plan must 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 must identify the medical or remedial services intended to reduce the identified condition, as well as the anticipated outcomes of the individual. The treatment plan must include a referral to self-help groups such as Alcoholics Anonymous (AA), Al-Anon, and Narcotics Anonymous (NA). The treatment plan must specify the frequency, amount and duration of services. (Refer to 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 must 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 must be developed if there is no measureable reduction of disability or restoration of functional level. The new plan must 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.

An interdisciplinary team of appropriately trained clinicians, such as physicians, nurses, counselors, social workers and psychologists, is available to assess and treat the individual and to obtain and interpret information regarding the patient's needs. The number and disciplines of team members are appropriate to the range and severity of the individual's problems.

Level 1 Outpatient Treatment

Outpatient level 1 services are professionally directed assessment, diagnosis, treatment, and recovery services provided in an organized non-residential treatment setting. Outpatient services are organized activities which may be delivered in any appropriate community setting that meets State licensure.

These services include, but are not limited to, individual, group, family counseling and psycho-education on recovery and wellness. 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.

Admission Guidelines (ASAM Level 1)

Outpatient level 1 services are available to members who meet the following criteria. The member exhibits:

1. **Acute intoxication and/or withdrawal potential** – No signs or symptoms of withdrawal, or individual's withdrawal can be safely managed in an outpatient setting;

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2. **Biomedical conditions and complications** – None, or sufficiently stable to permit participation in outpatient treatment;
3. **Emotional, behavioral or cognitive conditions and complications** – None or minimal. If present, symptoms are mild, stable and do not interfere with the patient’s ability to participate in treatment;
4. **Readiness to change** – Member should be open to recovery but require monitoring and motivating strategies to engage in treatment and to progress through the stages of change but not be in need of a structured milieu program;
5. **Relapse, continued use or continued problem potential** – Member is able to achieve abstinence and related recovery goals, with support and scheduled therapeutic contact to assist with issues that include, but not limited to, ambivalence about preoccupation of alcohol use or other drug use, cravings, peer pressure and lifestyle and attitude changes; and
6. **Recovery environment** – Environment is sufficiently supportive that outpatient treatment is feasible, or the individual does not have an adequate, primary or social support system but has demonstrated motivation and willingness to obtain such a support system.

Additional Admission Guidelines (ASAM Level 1)

Additional admission guidelines for level 1 outpatient treatment services are:

1. Initial point of entry/reentry - Activities related to assessment, evaluation, diagnosis and assignment of level of care are provided, including transfer between facilities and/or treatment levels, relapse assessment and assignment to level of care;
2. Early intervention for those who have been identified as individuals suffering from addictive disorders and referred for education, activities or support services designed to prevent progression of disease;
3. Continuing care for those who require a step-down, following a more intensive level of care and require minimal support to avoid relapse; and/or
4. Any combination of the above.

Screening, Assessment and Treatment Plan Review (ASAM Level 1)

Refer to *Core Requirements* in the general section.

An individualized, interdisciplinary treatment plan, which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals must be developed in collaboration with the member. The treatment plan is then reviewed/updated in collaboration with the member, as needed, as required by that level of care, but at a minimum of every 90 days or more frequently if indicated by the member’s needs and documented accordingly. Discharge/transfer planning must begin at admission and referral arrangements are made, as needed.

Provider Qualifications (ASAM Level 1)

In addition to the agency and staff qualifications noted for addiction service providers, the following is required for ASAM Level 1.

Staffing Requirements (ASAM Level 1)

The provider must ensure the following:

1. The provider must have a medical director (physician);
2. There are physician services available as needed for the management of psychiatric and medical needs of the members. Physician services may be provided directly by the behavioral health services (BHS) provider or may be provided or arranged via written contract, agreement, policy, or other document. The BHS provider must maintain documentation of such arrangement;
3. There is a clinical supervisor available on-site for supervision as needed, and available on call at all times;
4. There is at least one LMHP or UP under the supervision of an LMHP on-site when clinical services are being provided;
5. Each LMHP or UP caseload does not exceed a ratio of 1:50 active members; and

6. There are nursing services available as needed to meet the nursing needs of the members. Nursing services may be provided directly by the provider or may be provided or arranged via written contract, agreement, policy, or other document. The provider must maintain documentation of such arrangement.

Additional Staffing and Service Components (ASAM Level 1)

An LMHP must be available (defined as on-site or available by phone) at all times for crisis intervention. An LMHP, who is a qualified clinical supervisor must be available for clinical supervision as needed and by telephone for consultation. The term supervision refers to clinical support, guidance and consultation afforded to unlicensed staff, and should not be confused with clinical supervision of bachelor’s or master’s level individuals or provisionally licensed individuals pursuing licensure. Such individuals must comply with current, applicable scope of practice and supervisory requirements identified by their respective licensing boards.

A peer specialist is recommended.

Counseling groups should not exceed 12 individuals. Educational group size is not restricted.

Level 2.1 Intensive Outpatient Treatment

Intensive outpatient treatment is professionally directed assessment, diagnosis, treatment, and recovery services provided in an organized non-residential treatment setting. Intensive outpatient services are organized activities which may be delivered in any appropriate community setting that meets State licensure.

These services include, but are not limited to, individual, group, family counseling and psycho-education on recovery, as well as monitoring of drug use, medication management, medical and psychiatric examinations, crisis intervention coverage and orientation to community-based support groups. Intensive outpatient program services must include evidence-informed practices, such as cognitive behavioral therapy (CBT), motivational interviewing and multidimensional family therapy. These programs offer comprehensive, coordinated and defined services and must have a minimum of three (3) hour groups three (3) days per week (nine (9) contact hours) for adults and a minimum of three (3) hour groups two (2) days per week (six (6) contact hours) for adolescents.

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Requirements by Population			
	Group Hours	Weekly	Minimum Contact Hours
Adults	Minimum of 3	3x/week	9
Adolescents	Minimum of 3	2x/week	6

Three (3) hour ASAM 2.1 groups must not be provided more than five (5) days per week. A minimum of one (1) individual session is required per thirty (30) days and no more than four (4) individual sessions may be provided within a thirty (30) day period. The maximum number of treatment hours is nineteen (19) hours per week for this level of care for adults and adolescents. This level consists of a scheduled series of face-to-face sessions appropriate to the individual’s POC.

Service Type Requirements			
	Hours	Treatment	Maximum Treatment Hours
Group Hours	3	<5 days	19 hours weekly (adults and adolescents)
Individual Sessions	1-4	30 days	

Admission guidelines (ASAM Level 2.1)

ASAM level 2.1 services are available to members who meet the following criteria. The member exhibits:

1. **Acute intoxication and/or withdrawal potential** – No signs or symptoms of withdrawal, or individual’s withdrawal can be safely managed in an intensive outpatient setting;
2. **Biomedical conditions and complications** – None, or sufficiently stable to permit participation in outpatient treatment;
3. **Emotional, behavioral or cognitive conditions and complications** – None to moderate. If present, member must be admitted to either a co-occurring disorder

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capable or co-occurring disorder enhanced program, depending on the member’s level of function, stability and degree of impairment;

- 4. **Readiness to change** – Member requires structured therapy and a programmatic milieu to promote treatment progress and recovery. The member’s perspective inhibits their ability to make behavioral changes without repeated, structured and clinically directed motivational interventions;
- 5. **Relapse, continued use or continued problem potential** – Member is experiencing an intensification of symptoms related to substance use, and their level of functioning is deteriorating despite modification of the treatment plan; and
- 6. **Recovery environment** – Insufficiently supportive environment and member lacks the resources or skills necessary to maintain an adequate level of functioning without services in intensive outpatient treatment.

Additional Admission Guidelines (ASAM Level 2.1)

Additional admission guidelines for level 2.1 intensive outpatient treatment services are:

- 1. Initial point of entry/re-entry – Activities related to assessment, evaluation, diagnosis and assignment of level of care are provided, including transfer between facilities and/or treatment modalities, relapse assessment and assignment to level of care;
- 2. Services may be provided for persons at risk of being admitted to more intensive levels of care, such as residential, inpatient or withdrawal management;
- 3. Continuing care for those who require a step-down following a more intensive level of care and require support to avoid relapse; and/or
- 4. Any combination of the above.

Screening, Assessment and Treatment Plan Review (ASAM Level 2.1)

Refer to *Core Requirements* in the general section.

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An individualized, interdisciplinary treatment plan, which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals must be developed in collaboration with the member. The treatment plan is reviewed/updated in collaboration with the member, as needed, or at minimum of every 30 days or more frequently if indicated by the member’s needs and documented accordingly. Discharge/transfer planning must begin at admission and referral arrangements, made as needed.

Provider Qualifications (ASAM Level 2.1)

In addition to the agency and staff qualifications noted for addiction service providers, the following qualifications are required for ASAM Level 2.1.

Staffing Requirements (ASAM Level 2.1)

The provider must ensure that:

1. The provider must have a medical director (physician);
2. A physician is on-site as needed for the management of psychiatric and medical needs and on call 24 hours per day, seven days per week;
3. There is a clinical supervisor on-site 10 hours a week and on call 24 hours per day, seven days per week;
4. There is at least one LMHP or UP under the supervision of an LMHP on-site when clinical services are being provided;
5. Each LMHP/UP caseload does not exceed a ratio of 1:25 active members;
6. There are nursing services available as needed to meet the nursing needs of the members; and
7. Nursing services may be provided directly by the BHS provider or may be provided or arranged via written contract, agreement, policy, or other document. The BHS provider must maintain documentation of such arrangement.

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Additional Staffing and Service Components (ASAM Level 2.1)

An LMHP must be available (defined as on-site or available by phone) at all times for crisis intervention. An LMHP, who is a qualified clinical supervisor must be available for clinical supervision as needed and by telephone for consultation. The term supervision refers to clinical support, guidance and consultation afforded to unlicensed staff, and should not be confused with clinical supervision of bachelor’s or master’s level individuals or provisionally licensed individuals pursuing licensure. Such individuals must comply with current, applicable scope of practice and supervisory requirements identified by their respective licensing boards.

A peer specialist is recommended.

Counseling groups should not exceed 12 individuals. Educational group size is not restricted.

Level 2-WM Ambulatory Withdrawal Management with Extended On-Site Monitoring

This level of care is an organized outpatient service, which may be delivered in an office setting, health care or addiction treatment facility by trained clinicians, who provide medically supervised evaluation, withdrawal management and referral services. The care is delivered in an office/health care setting or BH treatment facility.

These services are designed to treat the individual’s level of clinical severity to achieve safe and comfortable withdrawal from mood-altering chemicals and to effectively facilitate the individual’s entry into ongoing treatment and recovery. Withdrawal management is conducted on an outpatient basis. It is important for medical and nursing personnel to be readily available to evaluate and confirm that withdrawal management in the less supervised setting is relatively safe. Counseling services may be available through the withdrawal management program or may be accessed through affiliation with entities providing outpatient services. Ambulatory withdrawal management is provided in conjunction with ASAM level 2.1 intensive outpatient treatment services.

Admission guidelines (ASAM Level 2-WM)

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

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1. **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;
2. **Biomedical conditions and complications** – None or sufficiently stable to permit participation in ambulatory withdrawal management in an outpatient setting;
3. **Emotional, behavioral or cognitive conditions and complications** – None to moderate. If present, complications can be safely addressed through monitoring, medication and treatment;
4. **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;
5. **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; and
6. **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.

Screening, Assessment, and Treatment Plan Review (ASAM Level 2-WM)

See *Core Requirements* in the general section.

An individualized, interdisciplinary treatment plan which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals must be developed in collaboration with the member. The treatment plan is reviewed/updated in collaboration with the member, as needed, or at minimum of every 30 days or more frequently if indicated by the member's needs and documented accordingly.

Discharge/transfer planning must begin at admission and referral arrangements made as needed.

Provider Qualifications (ASAM Level 2-WM)

In addition to the agency and staff qualifications noted for addiction service providers, the following qualifications are required for ASAM Level 2-WM.

Staffing Requirements (ASAM Level 2-WM)

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

The provider must ensure that:

1. The provider must have a medical director (physician);
2. A physician is on-site at least 10 hours per week during operational hours and on-call 24 hours per day, seven days per week;
3. A physician must be available to assess the individual within 24 hours of admission (or earlier, if medically necessary) and is available to provide on-site monitoring of care and further evaluation on a daily basis;
4. There is a clinical supervisor available on-site for supervision as needed and available on call at all times;
5. There is an LMHP or UP under the supervision of an LMHP on-site 40 hours per week;
6. Each LMHP/UP caseload does not exceed a ratio of 1:25 active members;
7. There is a licensed nurse on call 24 hours per day, seven days per week and on-site no less than 40 hours a week;
8. A nurse must be responsible for overseeing the monitoring of the individual's progress and medication. Appropriately licensed and credentialed staff is available to administer medications in accordance with physician orders; and
9. There is a RN on-site as needed to perform nursing assessments.

Additional Staffing and Service Components (ASAM Level 2-WM)

An LMHP, who is a qualified clinical supervisor must be available for clinical supervision as needed and by telephone for consultation. The term supervision refers to clinical support, guidance and consultation afforded to unlicensed staff, and should not be confused with clinical supervision of bachelor’s or master’s level individuals or provisionally licensed individuals pursuing licensure. Such individuals must comply with current, applicable scope of practice and supervisory requirements identified by their respective licensing boards.

A peer specialist is recommended.

Minimum Standards of Practice (ASAM Level 2-WM)

1. **Toxicology and drug screening** - Urine drug screens are required upon admission and as directed by the treatment plan and are considered covered under the rate paid to the provider;
2. **Stabilization/treatment plan** - A qualified professional must identify the individual's short-term needs, based on the withdrawal management history, the medical history and the physical examination and prepare a plan of action. The treatment plan must be reviewed and signed by the physician and the individual and must be filed in the individual's record within 24 hours of admission with updates, as needed;
3. **Progress notes** - The program must implement the stabilization/treatment plan and document the individual's response to and/or participation in scheduled activities. Notes must include the following:
 - a. The individual's physical condition, including vital signs;
 - b. The individual's mood and behavior;
 - c. Statements about the individual's condition and needs;
 - d. Information about the individual's progress or lack of progress in relation to stabilization/treatment goals; and
 - e. Additional notes must be documented, as needed.

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- 4. **Physicians’ orders** - Physicians’ orders are required for medical and psychiatric management.

The clinician will bill the appropriate Current Procedural Terminology (CPT) codes in conjunction with intensive outpatient program (IOP) codes (e.g., billing a minimum of nine hours of IOP).

Level 3.1 Clinically Managed Low Intensity Residential Treatment – Adolescent

Residential programs offer at least five hours per week of a combination of low-intensity clinical and recovery-focused services. Low-intensity residential treatment services for adolescents are directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility and reintegrating the individual into the worlds of work, education and family life. Services provided may include individual, group and family therapy, medication management and medication education. Mutual/self-help meetings usually are available on-site. This level of services does not include sober houses, boarding houses or group homes where treatment services are not provided.

Admission Guidelines (ASAM Level 3.1 Adolescent)

ASAM level 3.1 services for adolescents are available to members who meet the following criteria. The member exhibits:

- 1. **Acute intoxication and/or withdrawal potential** – None or minimal/stable withdrawal risk;
- 2. **Biomedical conditions and complications** – None or stable. If present, the member must be receiving medical monitoring;
- 3. **Emotional, behavioral or cognitive conditions and complications** – None or minimal. If present, conditions must be stable and not too distracting to the member’s recovery;
- 4. **Readiness to change** – Member should be open to recovery, but in need of a structured, therapeutic environment;

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5. **Relapse, continued use or continued problem potential** – Member understands the risk of relapse, but lacks relapse prevention skills or requires a structured environment; and
6. **Recovery environment** – Environment is dangerous, but recovery is achievable within a 24-hour structure.

Screening, Assessment, and Treatment Plan Review (ASAM Level 3.1 Adolescent)

Refer to *Core Requirements* in the general section.

An individualized, interdisciplinary treatment plan, which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals should be developed in collaboration with the member within 72 hours of admission. The treatment plan is reviewed in collaboration with the member every 90 days or more frequently if indicated by the member’s needs and documented accordingly. Discharge/transfer planning must begin at admission and referral arrangements made prior to discharge.

Provider Qualifications (ASAM Level 3.1 Adolescent)

In addition to the agency and staff qualifications noted for addiction service providers, the following qualifications are required for providers of ASAM Level 3.1 Adolescent.

Staffing Requirements (ASAM Level 3.1 Adolescent)

Facilities that provide ASAM level 3.1 services must have both qualified professional and support staff necessary to provide services appropriate to the bio-psychosocial needs of individuals being admitted to the program.

In addition to the staffing required by therapeutic group homes (TGH), Adolescent TGH ASAM 3.1 must have at least the following staffing:

1. The provider must have a medical director (physician);
2. The provider must have a clinical supervisor available for clinical supervision and by telephone for consultation;

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3. LMHP or UP under supervision of a an LMHP caseload must not exceed 1:8 active clients;
4. At least one LMHP or UP is on duty at least 40 hours a week when majority of individuals are awake and on-site;
5. The provider must have a house manager;
6. The provider must have at least two direct care aides (two FTE) on duty during each shift;
7. There must be a ratio of 1:8 direct care aides during all shifts and a ratio of 1:5 direct care aides on therapy outings; and
8. There must be a care coordinator and/or duties may be assumed by clinical staff.

Additional Staffing and Service Components (ASAM Level 3.1 Adolescent)

An LMHP, who is a qualified clinical supervisor, must be available for clinical supervision as needed and by telephone for consultation. The term supervision refers to clinical support, guidance and consultation afforded to unlicensed staff, and should not be confused with clinical supervision of bachelor’s or master’s level individuals or provisionally licensed individuals pursuing licensure. Such individuals must comply with current, applicable scope of practice and supervisory requirements identified by their respective licensing boards.

Licensed, certified or registered clinicians provide a planned regimen of 24-hour, professionally directed evaluation, care and treatment services for individuals.

A house manager is required to supervise activities of the facility when the professional staff is on call, but not on duty. This person is required to have adequate orientation and skills to assess situations related to relapse and to provide access to appropriate medical care when needed.

Clerical support staff (one FTE) is recommended.

A peer specialist is recommended.

Level 3.1 Clinically Managed Low-Intensity Residential Treatment – Adult

Level 3.1 residential programs offer at least five hours per week of a combination of low-intensity clinical and recovery-focused services. Low-intensity residential treatment services for adults are directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility and reintegrating the individual into the worlds of work, education and family life. Services provided may include individual, group and family therapy, medication management and medication education. Mutual/self-help meetings usually are available on-site. Facilities that provide low-intensity, clinical, and recovery-focused services do not include sober living houses, boarding houses or group homes where treatment services are not provided. (An example is a halfway house).

Admission Guidelines (ASAM Level 3.1 Adult)

Level 3.1 residential services for adults are available to members who meet the following criteria. The member exhibits:

1. **Acute intoxication and/or withdrawal potential** – None, or minimal/stable withdrawal risk;
2. **Biomedical conditions and complications** – None or stable. If present, the member must be receiving medical monitoring;
3. **Emotional, behavioral or cognitive conditions and complications** – None or minimal. If present, conditions must be stable and not too distracting to the member’s recovery;
4. **Readiness to change** – Member should be open to recovery but in need of a structured, therapeutic environment;
5. **Relapse, continued use or continued problem potential** – Member understands the risk of relapse but lacks relapse prevention skills or requires a structured environment; and
6. **Recovery environment** – Environment is dangerous, but recovery is achievable within a 24-hour structure.

Screening, Assessment, and Treatment Plan Review (ASAM Level 3.1 Adult)

Refer to *Core Requirements* in the general section.

An individualized, interdisciplinary treatment plan, which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals must be developed in collaboration with the member within 72 hours of admission. The treatment plan is reviewed in collaboration with the member every 90 days or more frequently of indicated by the member's needs and documented accordingly. Discharge/transfer planning must begin at admission and referral arrangements made prior to discharge.

Provider Qualifications (ASAM Level 3.1 Adult)

In addition to the agency and staff qualifications noted for addiction service providers, the following qualifications are required for providers of ASAM Level 3.1 Adults.

Staffing Requirements (ASAM Level 3.1 Adult)

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

The provider must ensure the following staffing:

1. The provider must have a medical director (physician);
2. The provider must have a clinical supervisor available for clinical supervision and by telephone for consultation;
3. LMHP or UP under supervision of an LMHP caseload must not exceed 1:25 active clients;
4. There must be at least one LMHP or UP on duty at least 40 hours a week when majority of individuals are awake and on-site;
5. The provider must have a house manager;
6. The provider must have at least one direct care aides (one FTE on all shifts; additional staff as needed) on duty during each shift; and

- 7. There must be a care coordinator and/or duties may be assumed by clinical staff.

Additional Staffing and Service Components (ASAM Level 3.1 Adult)

An LMHP, who is a qualified clinical supervisor, must be available for clinical supervision as needed and by telephone for consultation. The term supervision refers to clinical support, guidance and consultation afforded to unlicensed staff, and should not be confused with clinical supervision of bachelor’s or master’s level individuals or provisionally licensed individuals pursuing licensure. Such individuals must comply with current, applicable scope of practice and supervisory requirements identified by their respective licensing boards.

Licensed, certified or registered clinicians provide a planned regimen of 24-hour, professionally directed evaluation, care and treatment services for individuals.

A house manager is required to supervise activities of the facility when the professional staff is on call, but not on duty. This person is required to have adequate orientation and skills to assess situations related to relapse and to provide access to appropriate medical care when needed.

Clerical support staff (one FTE) is recommended.

A peer specialist is recommended.

Level 3.2-WM Clinically Managed Residential Social Withdrawal Management – Adolescent

Residential programs provided in an organized, residential, non-medical setting delivered by an appropriately trained staff that provides safe, 24-hour medication monitoring, observation and support in a supervised environment for a person served, to achieve initial recovery from the effects of alcohol and/or other drugs. Social withdrawal management is appropriate for individuals who are able to participate in the daily residential activities and is often used as a less restrictive, non-medical alternative to inpatient withdrawal management.

Admission Guidelines (ASAM Level 3.2-WM – Adolescent)

Facilities that provide ASAM level 3.2-WM services to adolescents provide care to patients whose withdrawal signs and symptoms are non-severe but require 24-hour inpatient care to address biomedical and recovery environment conditions/complications. Twenty-four-hour observation,

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monitoring and treatment are available. However, the full resources of an acute care general hospital or a medically supported program are not necessary.

1. **Acute intoxication and/or withdrawal potential** – The patient 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 patient 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 patient has little awareness and need intervention available to prevent continued use, with imminent dangerous consequences because of cognitive deficits; and
6. **Recovery environment** – The patient’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.

Emergency Admissions (ASAM Level 3.2-WM Adolescent)

The admission process may be delayed only until the individual can be interviewed, but no longer than 24 hours, unless seen by a physician. Facilities are required to orient direct care employees to monitor, observe and recognize early symptoms of serious illness and to access emergency services promptly.

Screening, Assessment and Treatment Plan Review (ASAM Level 3.2-WM Adolescent)

Refer to *Core Requirements* in the general section.

An individualized stabilization/treatment plan must be developed in collaboration with the member within 24 hours. Discharge/transfer planning must begin at admission and referral arrangements must be made, as needed.

Daily assessment of progress through withdrawal management must be documented in a manner that is person-centered and individualized.

Provider Qualifications - (ASAM Level 3.2-WM Adolescent)

In addition to the agency and staff qualifications noted for addiction service providers, the following qualifications are required for providers of ASAM Level 3.2-WM Adolescent.

Staffing Requirements (ASAM Level 3.2-WM Adolescent)

Facility must have qualified professional and other support staff necessary to provide services appropriate to the needs of individuals being admitted to the program.

In addition to the staffing required by TGH, Adolescent TGH ASAM 3.2-WM must have at least the following staffing:

1. The provider must have a medical director (physician);
2. There is a physician on call 24 hours per day, seven days per week and on duty as needed for management of psychiatric and medical needs of the client. Duties would include:
 - a. Review and approve on medical treatment; and
 - b. Triage medical needs at admission and through course of stay for all members.
3. Clinical supervisor is available for clinical supervision when needed and by telephone for consultation;

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- 4. A minimum of one LMHP or UP under supervision of an LMHP available on-site at least 40 hours per week;
- 5. Each LMHP/UP’s caseload must not exceed a ratio of 1:16;
- 6. There must be two direct care aides (two full time employees) per shift with additional as needed, not to exceed a ratio of 1:10;
- 7. There must be at least one clerical support staff per day shift; and
- 8. There must be a care coordinator (One full time employee per day shift), and/or duties may be assumed by clinical staff).

Additional Staffing and Service Components (ASAM Level 3.2-WM Adolescent)

An LMHP, who is a qualified clinical supervisor, must be available for clinical supervision as needed and by telephone for consultation. The term supervision refers to clinical support, guidance and consultation afforded to unlicensed staff, and should not be confused with clinical supervision of bachelor’s or master’s level individuals or provisionally licensed individuals pursuing licensure. Such individuals must comply with current, applicable scope of practice and supervisory requirements identified by their respective licensing boards.

Licensed, certified or registered clinicians provide a planned regimen of 24-hour, professionally directed evaluation, care and treatment services for individuals.

A peer specialist is recommended.

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

- 1. **History** - The program must obtain enough medical and psychosocial information about the individual to provide a clear understanding of the individual's present status. Exceptions must be documented in individual’s treatment record;
- 2. **Medical clearance and screening** - Medical screening is performed upon arrival, by staff with current CPR and first aid training, with telephone access to RN physician for instructions for the care of the individual. Individuals who require

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medication management must be transferred to medically monitored or medical withdrawal management program until stabilized;

- 3. **Toxicology and drug screening**– Toxicology and drug screenings are medically monitored. A physician may waive drug screening if and when an individual signs a list of drugs being used and understands that their dishonesty could result in severe medical reactions during the withdrawal management process;
- 4. **Stabilization/treatment plan** - The stabilization/treatment plan must be reviewed and signed by the qualified professional and the individual and must be filed in the individual's record within 24 hours of admission with updates, as needed;
- 5. **Progress notes** - The program must implement the stabilization/treatment plan and document the individual's response to and/or participation in scheduled activities. Notes must include:
 - a. The individual's physical condition, including vital signs;
 - b. The individual's mood and behavior;
 - c. Individual statements about the individual's condition and needs;
 - d. Information about the individual's progress or lack of progress in relation to stabilization/treatment goals; and
 - e. Additional notes must be documented, as needed.
- 6. **Physicians' orders** – Physicians’ orders are required for medical and psychiatric management.

Level 3.2-WM Clinically Managed Residential Social Withdrawal Management – Adult

Residential programs provided in an organized, residential, non-medical setting delivered by an appropriately trained staff that provides safe, 24-hour medication monitoring observation and support in a supervised environment for a person served to achieve initial recovery from the effects of alcohol and/or other drugs. Social withdrawal management is appropriate for individuals who

are able to participate in the daily residential activities and is often used as a less restrictive, non-medical alternative to inpatient withdrawal management.

Admission Guidelines (ASAM Level 3.2-WM Adult)

Facilities that provide ASAM level 3.2 services to adults provide care to patients whose withdrawal signs and symptoms are non-severe but require 24-hour inpatient care to address biomedical and recovery environment conditions/complications. Twenty-four-hour observation, monitoring and treatment are available. However, the full resources of an acute care general hospital or a medically supported program are not necessary.

1. **Acute intoxication and/or withdrawal potential** – The patient 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 patient 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 patient has little awareness and need intervention available to prevent continued use, with imminent dangerous consequences because of cognitive deficits; and
6. **Recovery environment** – The patient’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.

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Emergency Admissions (ASAM Level 3.2-WM Adult)

The admission process may be delayed only until the individual can be interviewed but no longer than 24 hours, unless assessed and evaluated by a physician. Facilities are required to orient direct care employees to monitor, observe and recognize early symptoms of serious illness and to access emergency services promptly.

Screening, Assessment and Treatment Plan Review (ASAM Level 3.2-WM Adult)

Refer to *Core Requirements* in the general section.

An individualized stabilization/treatment plan must be developed in collaboration with the member within 24 hours. Discharge/transfer planning must begin at admission and referral arrangements should be made, as needed.

Daily assessment of progress, through withdrawal management, must be documented in a manner that is person-centered and individualized.

Provider Qualifications (ASAM Level 3.2-WM Adult)

In addition to the agency and staff qualifications noted for addiction service providers, the following qualifications are required for providers of ASAM Level 3.2-WM Adult.

Staffing Requirements (ASAM Level 3.2-WM Adult)

Facility must have qualified professional and other support staff necessary to provide services appropriate to the needs of individuals being admitted to the program.

The provider must ensure that the following criteria are met:

1. The provider must have a medical director (physician);
2. There is a physician on call 24 hours per day, seven days per week and on duty as needed for management of psychiatric and medical needs of the clients. Duties would include:
 - a. Review and approve on medical treatment; and

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- b. Triage medical needs at admission and through course of stay for all members.
- 3. Clinical supervisor is available for clinical supervision when needed and by telephone for consultation;
- 4. A minimum of one LMHP or UP under the supervision of an LMHP available on-site at least 40 hours per week (may be combination of two or more professional disciplines);
- 5. Each LMHP/UP’s caseload must not exceed a ratio of 1:25;
- 6. There must be one direct care aide (one full-time employee) per shift with additional as needed;
- 7. There must be at least one clerical support staff per day shift; and
- 8. There must be a care coordinator (one full-time employee per day shift), and/or duties may be assumed by clinical staff).

Additional Staffing and Service Components (ASAM Level 3.2-WM Adult)

An LMHP, who is a qualified clinical supervisor, must be available for clinical supervision as needed and by telephone for consultation. The term ‘supervision’ refers to clinical support, guidance and consultation afforded to unlicensed staff, and should not be confused with clinical supervision of bachelor’s or master’s level individuals or provisionally licensed individuals pursuing licensure. Such individuals must comply with current, applicable scope of practice and supervisory requirements identified by their respective licensing boards.

Licensed, certified or registered clinicians provide a planned regimen of 24-hour, professionally directed evaluation, care and treatment services for individuals.

A peer specialist is recommended.

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

1. **History** - The program must obtain enough medical and psychosocial information about the individual to provide a clear understanding of the individual's present status. Exceptions must be documented in the individual's record;
2. **Medical clearance and screening** - Medical screening is performed upon arrival by staff with current CPR and first aid training, with telephone access to RN physician for instructions for the care of the individual. Individuals who require medication management must be transferred to medically monitored or medical withdrawal management program until stabilized;
3. **Toxicology and drug screening** – Toxicology and drug screenings are medically monitored. A physician may waive drug screening if and when an individual signs a list of drugs being used and understands that their dishonesty could result in severe medical reactions during the withdrawal management process;
4. **Stabilization/treatment plan** - The stabilization/treatment plan must be reviewed and signed by the qualified professional and the individual and must be filed in the individual's record within 24 hours of admission with updates, as needed;
5. **Progress notes** - The program must implement the stabilization/treatment plan and document the individual's response to and/or participation in scheduled activities. Notes must include:
 - a. The individual's physical condition, including vital signs;
 - b. The individual's mood and behavior;
 - c. Individual statements about the individual's condition and needs;
 - d. Information about the individual's progress or lack of progress in relation to stabilization/treatment goals; and
 - e. Additional notes must be documented, as needed.
6. **Physicians' orders** – Physicians' orders are required for medical and psychiatric management.

Level 3.3 Clinically Managed Medium Intensity Residential Treatment - Adult

Level 3.3 residential programs offer at least 20 hours per week of a combination of medium-intensity clinical and recovery-focused services.

Frequently referred to as extended or long-term care, Level 3.3 programs provide a structured recovery environment in combination with medium-intensity clinical services to support recovery from substance-related disorders.

Admission Guidelines (ASAM Level 3.3 Adult)

ASAM level 3.3 adult services are available to members who meet the following criteria. The member exhibits the following:

1. **Acute intoxication and/or withdrawal potential** – None, or minimal risk of withdrawal;
2. **Biomedical conditions and complications** – None or stable. If present, the member must be receiving medical monitoring;
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 their 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 their substance use, addiction, mental health or life problems and impaired coping skills and level of functioning;
5. **Relapse, continued use or continued problem potential** – Has little awareness and needs intervention available to prevent continued use, they are in imminent

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danger of continued substance use or emotional health problems with dangerous emotional, behavioral or cognitive consequences. The member’s cognitive impairment has limited their ability to identify and cope with relapse triggers and high-risk situations. They require 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; and

6. **Recovery environment** – Environment is dangerous, but recovery is achievable within a 24-hour structure.

Screening, Assessment and Treatment Plan Review (ASAM Level 3.3 Adult)

Refer to *Core Requirements* in the general section.

An individualized, interdisciplinary treatment plan, which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals must be developed in collaboration with the member. The treatment plan is reviewed in collaboration with the member, as needed, or at a minimum of every 90 days or more frequently if indicated by the member’s needs and documented accordingly. Discharge and transfer planning should begin at admission and referral arrangements made prior to discharge.

Provider Qualifications (ASAM Level 3.3 Adult)

In addition to the agency and staff qualifications noted for addiction service providers, the following qualifications are required for providers of ASAM Level 3.3 Adult.

Staffing Requirements (ASAM Level 3.3 Adult)

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

The provider must ensure the following:

1. The provider must have a medical director (physician);
2. There is a physician on call 24 hours per day and on duty as needed for management of psychiatric and medical needs;

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3. There is a clinical supervisor available for clinical supervision when needed and by telephone for consultation;
4. There is an LMHP or UP under supervision of an LMHP on-site 40 hours a week to provide direct client care;
5. Each LMHP/UP caseload must not exceed 1:12;
6. There is 24 hour on-call availability by an RN plus a licensed nurse on duty whenever needed to meet the professional nursing requirements;
7. There is at least one direct care aide on duty for each shift plus additional aides as needed;
8. There must be a care coordinator (one FTE per 50 members per day shift, and/or duties may be assumed by clinical staff); and
9. There must be a clerical support staff (One FTE per day shift).

Additional Staffing and Service Components

An LMHP, who is a qualified clinical supervisor, must be available for clinical supervision as needed and by telephone for consultation. The term supervision refers to clinical support, guidance and consultation afforded to unlicensed staff, and should not be confused with clinical supervision of bachelor's or master's level individuals or provisionally licensed individuals pursuing licensure. Such individuals must comply with current, applicable scope of practice and supervisory requirements identified by their respective licensing boards.

Licensed, certified or registered clinicians provide a planned regimen of 24-hour, professionally directed evaluation, care and treatment services for individuals.

A peer specialist is recommended.

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

In addition to the requirement for ASAM Level 3.3 facilities, Mothers with Dependent Children Programs must follow additional guidelines and meet specific requirements (Reference: LAC 48:I Ch. 57, §5705C). Providers must:

1. Offer weekly parenting classes in which attendance is required;
2. Address the specialized needs of the parent;
3. Offer education, counseling and rehabilitation services for its parent members that further address:
 - a. Effects of chemical dependency on a women’s health and pregnancy;
 - b. Parenting skills; and
 - c. Health and nutrition.
4. Regularly assess parent-child interactions and address any identified needs in treatment;
5. Provide access to family planning services;
6. Be responsible for ensuring that it provides children supervision appropriate to the age of each child, when the mother is not available to supervise her child. Supervision must be provided either by the provider on-site program or a licensed daycare provider pursuant to a written agreement with the provider. Provider’s on-site program must ensure the following requirements are met:
 - a. Staff members are at least 18 years of age;
 - b. Staff members have infant CPR certification; and
 - c. Staff members have at least eight hours of training in the following areas prior to supervising children:

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- i. Chemical dependency and its impact on the family;
 - ii. Child development and age-appropriate activities;
 - iii. Child health and safety;
 - iv. Universal precautions;
 - v. Appropriate child supervision techniques;
 - vi. Signs of child abuse; or
 - vii. A licensed day care provider pursuant to a written agreement with the provider.
7. The provider must 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;
8. Employ a Child Specialist, who is available to provide staff training, evaluate effectiveness of direct care staff, and plan activities for at least one hour per week per child;
9. Maintain a personnel file of the Child Specialist has documentation verifying the required minimum of 90 clock hours of education and training in child development and/or early childhood education;
10. Maintain verification that the Child Specialist has a minimum of one year documented experience providing services to children;
11. The provider must 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
12. The daily activity schedule for the children must include a variety of structured and unstructured age appropriate activities.

Level 3.5 Clinically Managed Medium Intensity Residential Treatment – Adolescent

These programs are designed to treat persons who have significant social and psychological problems and are characterized by their reliance on the treatment community as a therapeutic agent. Treatment goals are to promote abstinence from substance use and antisocial behavior and to effect a global change in members’ lifestyles, attitudes and values. Individuals typically have multiple deficits, which may include substance-related disorders, criminal activity, psychological problems, impaired functioning and disaffiliation from mainstream values. The program must include an in-house education/vocational component if serving adolescents (Example: therapeutic community or residential treatment center).

Admission Guidelines (ASAM Level 3.5 Adolescent)

ASAM level 3.5 adolescent services are available to members who meet the following criteria. The member exhibits the following:

1. **Acute intoxication and/or withdrawal potential** - None or minimal risk of withdrawal;
2. **Biomedical conditions and complications** - None or stable or receiving concurrent medical monitoring;
3. **Emotional, behavioral or cognitive conditions and complications** - Demonstrates repeated inability to control impulses or a personality disorder requires structure to shape behavior. Other functional deficits require a 24-hour setting to teach coping skills. A co-occurring disorder-enhanced setting is required for severely and persistently mentally ill (SPMI) patients;
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 their substance use, addiction, mental health, or life problems and their 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;
5. **Relapse, continued use or continued problem potential** - Has no recognition of the skills needed to prevent continued use, with imminently dangerous

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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; and

6. **Recovery environment** - Living and social environments has a high risk of neglect or abuse, and member lacks skills to cope outside of a highly structured 24-hour setting.

Screening, Assessment and Treatment Plan Review (ASAM Level 3.5 Adolescent)

Refer to *Core Requirements* in the general section.

An individualized, interdisciplinary treatment plan which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals must be developed in collaboration with the member. The treatment plan is reviewed in collaboration with the member, as needed, or at a minimum of every 30 days or more frequently if indicated by the member’s needs and documented accordingly. Discharge/transfer planning must begin at admission and referral arrangements made prior to discharge.

Provider Qualifications (ASAM Level 3.5 Adolescent)

In addition to the agency and staff qualifications noted for addiction service providers, the following qualifications are required for providers of ASAM Level 3.5 Adolescent.

Staffing Requirements (ASAM Level 3.5 Adolescent)

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

The provider must ensure the following:

1. The provider must have a medical director (physician);
2. There is a physician on call 24 hours per day, seven days per week, and on duty as needed for management of psychiatric and medical needs of the clients;

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3. There is a psychologist available when needed;
4. There is a clinical supervisor available for clinical supervision when needed and by telephone for consultation;
5. There must be at least one LMHP or UP under the supervision of an LMHP on duty at least 40 hours per week;
6. Each LMHP/UP's caseload must not exceed 1:8;
7. The provider must have one licensed RN on call 24/7 to perform nursing duties for the provider;
8. Nursing availability on-site whenever needed to meet the nursing needs of the members. Nursing services may be provided directly by the BHS provider or may be provided or arranged via written contract, agreement, policy, or other document. The BHS provider must maintain documentation of such arrangement;
9. There must be at least two direct care aides on duty (two FTE) during all shifts with additional as needed. The ratio of aides to clients must not exceed 1:8. On therapy outings, the ratio must be at least 1:5;
10. There must be a care coordinator (one FTE per day shift, and/or duties may be assumed by clinical staff); and
11. There must be a clerical support staff (One FTE per day shift).

Additional Staffing and Service Components (ASAM Level 3.5 Adolescent)

An LMHP, who is a qualified clinical supervisor, must be available for clinical supervision as needed and by telephone for consultation. The term 'supervision' refers to clinical support, guidance and consultation afforded to unlicensed staff, and should not be confused with clinical supervision of bachelor's or master's level individuals or provisionally licensed individuals pursuing licensure. Such individuals must comply with current, applicable scope of practice and supervisory requirements identified by their respective licensing boards.

Licensed, certified or registered clinicians provide a planned regimen of 24-hour, professionally directed evaluation, care and treatment services for individuals and their families.

An activity/occupational therapist is optional.

A peer specialist is recommended.

Level 3.5 Clinically Managed High Intensity Residential Treatment – Adult

The level 3.5 adult residential treatment program is designed to treat persons who have significant social and psychological problems. Programs are characterized by their reliance on the treatment community as a therapeutic agent. Treatment goals are to promote abstinence from substance use and antisocial behavior and to effect a global change in members' lifestyles, attitudes and values. Individuals typically have multiple deficits, which may include substance-related disorders, criminal activity, psychological problems, impaired functioning and disaffiliation from mainstream values (Example: therapeutic community or residential treatment center).

Admission Guidelines (ASAM Level 3.5 Adult)

ASAM level 3.5 adult services are available to members who meet the following criteria. The member exhibits the following:

1. **Acute intoxication and/or withdrawal potential** - None, or minimal risk of withdrawal;
2. **Biomedical conditions and complications** - None or stable or receiving concurrent medical monitoring;
3. **Emotional, behavioral or cognitive conditions and complications** - Demonstrates repeated inability to control impulses, or a personality disorder requires structure to shape behavior. Other functional deficits require a 24-hour setting to teach coping skills. A Co-Occurring Disorder Enhanced setting is required for SPMI patients;
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 their substance use, addiction, mental health, or life problems and their 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;

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- 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; and
- 6. **Recovery environment** - Living and social environments has a high risk of neglect or abuse, and member lacks skills to cope outside of a highly structured 24-hour setting.

Screening, Assessment, and Treatment Plan Review (ASAM Level 3.5 Adult)

Refer to *Core Requirements* in the general section.

An individualized, interdisciplinary treatment plan, which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals must be developed in collaboration with the member. The treatment plan is reviewed in collaboration with the member, as needed, or at a minimum of every 30 days or more frequently if indicated by the member’s needs and documented accordingly. Discharge/transfer planning must begin at admission and referral arrangements made prior to discharge.

Provider Qualifications (ASAM Level 3.5 Adult)

In addition to the agency and staff qualifications noted for addiction service providers, the following qualifications are required for providers of ASAM Level 3.5 Adult.

Staffing Requirements (ASAM Level 3.5 Adult)

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

The provider must ensure the following:

- 1. The provider must have a medical director (physician);

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2. There is a physician on call 24 hours per day, seven days per week, and on duty as needed for management of psychiatric and medical needs of the clients;
3. There is a clinical supervisor available for clinical supervision when needed and by telephone for consultation;
4. There must be at least one LMHP or UP under supervision of an LMHP on duty at least 40 hours per week;
5. Each LMHP/UP's caseload must not exceed 1:12;
6. The provider must have one licensed RN on call 24/7 to perform nursing duties for the provider;
7. There must be at least one licensed nurse on duty during the day and evening shifts to meet the nursing needs of the clients. Nursing services may be provided directly by the BHS provider or may be provided or arranged via written contract, agreement, policy, or other document. The BHS provider must maintain documentation of such arrangement;
8. There must be at least one direct care aide on duty on all shifts with additional as needed;
9. There must be a care coordinator (one FTE per day shift, and/or duties may be assumed by clinical staff); and
10. There must be a clerical support staff (One FTE per day shift).

Additional Staffing and Service Components (ASAM Level 3.5 Adult)

An LMHP, who is a qualified clinical supervisor must be available for clinical supervision as needed and by telephone for consultation. The term supervision refers to clinical support, guidance and consultation afforded to unlicensed staff, and should not be confused with clinical supervision of bachelor's or master's level individuals or provisionally licensed individuals pursuing licensure. Such individuals must comply with current, applicable scope of practice and supervisory requirements identified by their respective licensing boards.

Licensed, certified or registered clinicians provide a planned regimen of 24-hour, professionally directed evaluation, care and treatment services for individuals and their families.

A psychologist is optional.

An activity/occupational therapist is optional.

A peer specialist is recommended.

Level 3.7 Medically Monitored Intensive Inpatient Treatment – Adult

This co-occurring disorder (COD) residential treatment facility provides 24 hour care including psychiatric and substance use assessments, diagnosis, treatment, habilitative and rehabilitation services to individuals with co-occurring psychiatric and substance disorders, whose disorders are of sufficient severity to require a residential level of care. It also features professionally directed evaluation, observation and medical monitoring of addiction and mental health treatment in a residential setting. They feature permanent facilities, including residential beds, and function under a defined set of policies, procedures and clinical protocols. Appropriate for patients whose sub-acute biomedical and emotional, behavioral or cognitive problems are so severe that they require co-occurring capable or enhanced residential treatment, but who do not need the full resources of an acute care general hospital. In addition to meeting integrated service criteria, COD treatment providers must have experience and preferably licensure and/or certification in both addictive disorders and mental health.

Admission Guidelines for ASAM Level 3.7 – Adult

Facilities that provide ASAM level 3.7 medically monitored intensive residential treatment services provide care for individuals who may have co-occurring addiction and mental health disorders that meet the eligibility criteria for placement in a co-occurring disorder-capable program or difficulties with mood, behavior or cognition related to a substance use or mental disorder or emotional behavioral or cognitive symptoms that are troublesome, but do not meet the Diagnostic and Statistical Manual for Mental Disorders (DSM) criteria for mental disorder.

ASAM level 3.7 Medically Monitored Intensive Inpatient Treatment – Adult services are available to members who meet the following criteria. The member exhibits the following:

1. **Acute intoxication and/or withdrawal potential** – None or minimal/stable withdrawal risk;

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

Screening/Assessment/Treatment Plan Review (ASAM Level 3.7 Adult)

Refer to Core Requirements in the general section.

An individualized, interdisciplinary treatment plan, which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals s be developed in collaboration with the member. The treatment plan is reviewed/updated in collaboration with the member, as needed, or at a minimum of every 30 days or as required by the member’s needs.

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Discharge/transfer planning must begin at admission and referral arrangements made prior to discharge.

Provider Qualifications (ASAM Level 3.7 Adult)

In addition to the agency and staff qualifications noted for addiction service providers, the following qualifications are required for providers of ASAM Level 3.7 Adult.

Staffing Requirements (ASAM Level 3.7 Adult)

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

The provider must ensure:

1. The provider must have a medical director (physician);
2. There is a physician on call 24 hours per day, seven days per week, and on duty as needed for management of psychiatric and medical needs;
3. There is a clinical supervisor available for clinical supervision when needed and by telephone for consultation;
4. There is at least one LMHP or UP under the supervision of an LMHP on duty at least 40 hours/week;
5. Each LMHP/UP caseload must not exceed 1:10;
6. There is at least one RN on call 24 hours per day, seven days per week to perform nursing duties and at least one licensed nurse is on duty during all shifts with additional licensed nursing staff to meet the nursing needs of the clients;
7. On-site nursing staff is solely responsible for the 3.7 program and does not provide services for other levels of care at the same time;
8. There is at least one direct care aide on duty on all shifts with additional as needed

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- 9. There is an activity or recreational therapist on duty at least 15 hours per week
- 10. There must be a care coordinator (one FTE per day shift, and/or duties may be assumed by clinical staff); and
- 11. There must be a clerical support staff (One FTE per day shift).

Additional Staffing and Service Components (ASAM Level 3.7 Adult)

Licensed, certified or registered clinicians provide a planned regimen of 24-hour, professionally directed evaluation, care and treatment services for individuals and their families.

An interdisciplinary team of appropriately trained clinicians, such as physicians, nurses, counselors, social workers and psychologists is available to assess and treat the individual and to obtain and interpret information regarding the patient’s needs. The number and disciplines of team members are appropriate to the range and severity of the individual’s problems.

A psychologist is optional.

A peer specialist is recommended.

Level 3.7-WM Medically Monitored Inpatient Withdrawal Management – Adult

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

Admission Guidelines (ASAM Level 3.7 WM Adult)

Facilities that provide ASAM Level 3.7-WM medically monitored inpatient withdrawal management services for adults provide care to patients whose withdrawal signs and symptoms are sufficiently severe to require 24-hour inpatient care. It sometimes is provided as a “step-down” service from a specialty unit of an acute care general or psychiatric hospital. Twenty-four-hour observation, monitoring and treatment are available; however, the full resources of an acute care general hospital or a medically managed intensive inpatient treatment program are not necessary.

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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; and
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.

Emergency Admissions (ASAM Level 3.7-WM Adult)

The process of admission may be delayed only until the individual can be interviewed but no longer than 24 hours, unless assessed and evaluated by a physician. Facilities are required to orient direct care employees to monitor, observe and recognize early symptoms of serious illness and to access emergency services promptly.

Screening/Assessments/Treatment Plan Review (ASAM Level 3.7 WM Adult)

Refer to *Core Requirements* in the general section.

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

An individualized, interdisciplinary stabilization/treatment plan must be developed in collaboration with the member, including problem identification in ASAM Dimensions 2-6. Discharge/transfer planning must begin at admission and referral arrangements made, as needed.

Daily assessment of member’s progress, which must be documented accordingly.

Provider Qualifications (ASAM Level 3.7 WM Adult)

In addition to the agency and staff qualifications noted for addiction service providers, the following qualifications are required for providers of ASAM Level 3.7 WM Adult.

Staffing Requirements (ASAM Level 3.7 WM Adult)

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

The provider must ensure that the facility has the following staffing:

1. The provider must have a medical director (physician);
2. The provider must have a physician on call 24 hours per day, seven days per week, and on duty as needed for management of psychiatric and medical needs of the clients;
3. The provider must have at least one RN on call 24 hours per day, seven days per week to perform nursing duties;

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4. There must be at least one licensed nurse on duty during all shifts with additional as needed based upon the provider’s census and the clients’ acuity levels;
5. There must be a RN on-site no less than 40 hours per week who is responsible for conducting nursing assessments upon admission and delegating staffing assignments to the nursing staff based on the assessments and the acuity levels of the clients;
6. The provider must ensure that its on-site nursing staff is solely responsible for 3.7-WM program and does not provide services for other levels of care at the same time;
7. The nursing staff is responsible for monitoring member’s progress and administering medications in accordance with physician orders;
8. The provider must have a clinical supervisor available for clinical supervision when needed and by telephone for consultation;
9. The LMHP or UP under the supervision of an LMHP caseload must not exceed 1:10;
10. At a minimum of one LMHP or UP under supervision of an LMHP is available on-site at least 40 hours per week;
11. There must be at least one direct care aide on all shifts with additional as needed based upon the provider’s census and the clients’ acuity levels.;
12. There must be a care coordinator (one FTE per day shift, and/or duties may be assumed by clinical staff); and
13. There must be a clerical support staff (One FTE per day shift).

Additional Staffing and Service Components (ASAM Level 3.7 WM Adult)

An LMHP, who is qualified clinical supervisor, must be available for clinical supervision as needed and by telephone for consultation as needed. The term supervision refers to clinical support, guidance and consultation afforded to unlicensed staff, and should not be confused with clinical supervision of bachelor’s or master’s level individuals or provisionally licensed

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individuals pursuing licensure. Such individuals must comply with current, applicable scope of practice and supervisory requirements identified by their respective licensing boards.

Appropriately licensed and credentialed staff available to administer medications in accordance with physician orders.

Licensed, certified or registered clinicians provide a planned regimen of 24-hour, professionally directed evaluation, care and treatment services for individuals and their families.

A peer specialist is recommended.

Minimum Standards of Practice (ASAM Level 3.7 WM Adult)

1. **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 their dishonesty could result in severe medical reactions during withdrawal management process;
2. **Stabilization/treatment plan** – A qualified professional must identify the individual's short-term needs based on the withdrawal management history, the medical history and the physical examination, if available, and prepare a plan of action until individual becomes physically stable. The treatment plan must be reviewed and signed by the physician and the individual and must be filed in the individual's record within 24 hours of admission with updates, as needed;
3. **Progress notes** - The program must implement the stabilization/treatment plan and document the individual's response to and/or participation in scheduled activities. Notes must include:
 - a. The individual's physical condition, including vital signs;
 - b. The individual's mood and behavior;
 - c. Statements about the individual's condition and needs;
 - d. Information about the individual's progress or lack of progress in relation to stabilization/treatment goals; and

- e. Additional notes must be documented, as needed.
- 4. **Physicians' Orders** - Physicians' orders are required for medical and psychiatric management.

Level 4-WM: Medically Managed Intensive Inpatient Withdrawal Management

This hospital level of care is appropriate for those individuals whose acute biomedical, emotional, behavioral and cognitive problems are so severe that they require primary medical and nursing care. This program encompasses a planned regimen of 24-hour medically directed evaluation and withdrawal management in an acute care inpatient setting.

Although treatment is specific to substance use problems, the skills of the interdisciplinary team and the availability of support services allow the conjoint treatment of any co-occurring biomedical conditions and mental disorders that need to be addressed. A licensed provider providing inpatient treatment must assign one qualified staff for every four members in residence. The licensed provider must maintain sufficient employees on duty 24-hours a day to meet the needs and protect the safety of members. Employees on duty must be awake on all shifts. The program must include an in-house education/vocation component, if serving adolescents. A licensed provider providing inpatient treatment must provide a licensed physician or nurse on-site or on call, and licensed medical or nursing staff to monitor and administer medications on a 24-hour per day basis.

Admission Guidelines (ASAM Level 4 WM)

Facilities that provide Level 4-WM medically managed intensive inpatient withdrawal management services provide care to patients whose withdrawal signs and symptoms are sufficiently severe and unstable enough to require primary medical and nursing services on a 24-hour basis. This program offers intensive physical health and/or psychiatric care in a hospital setting. The focus is on stabilization and preparation for transfer to a less intensive level of care.

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.

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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 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;
4. **Readiness to change** – Refer to the admission guidelines above;
5. **Relapse, continued use or continued problem potential** –See admission guidelines above; and
6. **Recovery environment** – Refer to the admission guidelines above.

Screening/Assessments/Treatment Plan Review (ASAM Level 4 WM)

Refer to *Core Requirements* in the general section.

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

Comprehensive bio-psychosocial assessments are not required for this level of care.

An individualized, interdisciplinary stabilization/treatment plan must be developed in collaboration with the member, including problem identification in ASAM Dimensions 2-6. Daily assessments of member's progress must be documented. Discharge/transfer planning must begin at admission and referral arrangements prior to discharge.

Provider Qualifications (ASAM Level 4 WM)

ASAM Level 4 and 4-WM programs are licensed by LDH as hospitals and must be accredited by an LDH approved national accrediting body: CARF, COA or TJC. Denial, loss of, or any negative change in accreditation status must be reported to their contracted MCOs in writing within 24 hours of notification by the accreditation body.

Hospitals must comply with Emergency Preparedness regulations associated with 42 CFR §482.15 in order to participate in the Medicare or Medicaid program (Link to CMS Emergency Preparedness Regulation Guidance and Resources: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html>).

Regulations must be implemented by November 15, 2017. They include safeguarding human resources, maintaining business continuity and protecting physical resources. Facilities should incorporate the four core elements of emergency preparedness into their plans and comply with all components of CMS' Rule:

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

Staffing Requirements (ASAM Level 4 WM)

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

The provider must ensure the following:

1. The provider must have a medical director, who is a physician, on call 24 hours per day, seven days per week, and on-site as needed for management of psychiatric and medical needs of the clients. Physician’s assistants or APRN may perform duties within the scope of their practice as designated by physician;
2. There must be a full time nursing supervisor (APRN/RN) with 24 hour on-call availability;
3. An LMHP or UP under supervision of an LMHP is available 40 hours per week;
4. There must be a direct care aide;
5. There must be clerical support staff; and
6. There must be a care coordinator (one FTE per day shift, and/or duties may be assumed by clinical staff).

Additional Staffing and Service Components (ASAM Level 4 WM)

A physician is available to assess the individual within 24 hours of admission (or earlier, if medically necessary) and is available to provide on-site monitoring of care and further evaluation on a daily basis.

A RN or other licensed and credentialed nurse is available on call 24 hours per day and on-site no less than 40 hours per week and will conduct a nursing assessment on individuals at admission.

A nurse is responsible for overseeing the monitoring of the individual’s progress and medication administration on an hourly basis, if needed.

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Appropriately licensed and credentialed staff is available to administer medications in accordance with physician orders.

Licensed, certified or registered clinicians provide a planned regimen of 24-hour, professionally directed evaluation, care and treatment services for individuals and their families.

A peer specialist is recommended.

Minimum Standards of Practice (ASAM Level 4 WM)

1. **Toxicology and drug screening** - Urine drug screens are required upon admission and as directed by the treatment plan;
2. **Stabilization/treatment plan** - A qualified professional must identify the individual's short-term needs, based on the withdrawal management history, the medical history and the physical examination and prepare a plan of action. The treatment plan must be reviewed and signed by the physician and the individual and must be filed in the individual's record within 24 hours of admission with updates, as needed;
3. **Progress notes** - The program must implement the stabilization/treatment plan and document the individual's response to and/or participation in scheduled activities. Notes must include:
 - a. The individual's physical condition, including vital signs;
 - b. The individual's mood and behavior;
 - c. Statements about the individual's condition and needs;
 - d. Information about the individual's progress or lack of progress in relation to stabilization/treatment goals; and
 - e. Additional notes must be documented, as needed.
4. **Physicians' orders** - Physicians' orders are required for medical and psychiatric management.

Allowed Settings (ASAM Level 4 WM)

Level 4-WM services are provided in the below settings:

1. General hospital outpatient and inpatient settings for adults and children; and
2. Psychiatric hospital inpatient settings for children under age 21.

Eligibility Criteria (ASAM Level 4 WM)

1. All Medicaid-eligible adults; and
2. All Medicaid-eligible children.

Allowed Mode(s) of Delivery (ASAM Level 4 WM)

1. Inpatient.

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Opioid Treatment

The Medicaid program provides coverage for medically necessary Medication-Assisted Treatment (MAT) delivered in Opioid treatment programs (OTPs), including but not limited to Methadone treatment to all Medicaid-eligible adults and adolescents with Opioid Use Disorder (OUD).

Components

Screening

A screening is conducted to determine eligibility and appropriateness for admission and referral.

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 must ensure members have a substance use or Opioid use disorder (OUD). The member must have been addicted to opiates for at least one year before admission for treatment, or meet exception criteria, as set in federal regulations, as determined by a physician.

Alcohol and Drug Assessment and Referrals

A comprehensive bio-psychosocial assessment must be completed within the first seven days of admission, which substantiates treatment. For new admissions, the American Society of Addiction Medicine (ASAM) 6 Dimensional risk evaluation must be included in the assessment. The assessment must be reviewed and signed by a licensed mental health professional (LMHP). The comprehensive bio-psychosocial assessment must contain the following:

1. Circumstances leading to admission;
2. Past and present behavioral health concerns;
3. Past and present psychiatric and addictive disorders treatment;
4. Significant medical history and current health status;
5. Family and social history;

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6. Current living situation;
7. Relationships with family of origin, nuclear;
8. Family and significant others;
9. Education and vocational training;
10. Employment history and current status;
11. Military service history and current status;
12. Legal history and current legal status;
13. Emotional state and behavioral functioning, past and present; and
14. Strengths, weaknesses, and needs.

Ongoing assessment and referral services for individuals presenting a current or past use pattern of alcohol or other drug use is essential in the treatment of substance use disorders. The assessment is designed to gather and analyze information regarding a member's biopsychosocial, substance use 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 must comply with licensing standards and any further Louisiana Department of Health (LDH) standards outlined below in regard to assessment practices. Once an individual receives an assessment, a staff member must provide the individual with the identified clinical recommendations, including referral to alternative level of care or services. Assessments must include the consideration of appropriate psychopharmacotherapy. There must be evidence that the member was assessed to determine if MAT was a viable option of care, based on the substance use disorder (SUD) diagnosis, and an appropriate assignment to level of care was determined, with referral to other appropriate services as indicated.

OTP providers, when clinically appropriate, must address the following during the assessment and referral process:

1. Educate members on the proven effectiveness, benefits and risks of Food and Drug Administration approved MAT options for their SUD;
2. Refer to other MAT offsite as applicable; and
3. Document member education, access to MAT and member response in the progress notes.

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Treatment Planning Process

Treatment plans must be based on the assessments to include person-centered goals and objectives. The treatment plan must be developed within seven days of admission by the treatment team.

The treatment plan must:

1. Identify the services intended to reduce the identified condition, as well as the anticipated outcomes of the individual;
2. Include a referral to self-help groups such as Alcoholics Anonymous (AA), Al-Anon, and Narcotics Anonymous (NA);
3. Must specify the frequency, amount and duration of services. (Refer to 2.6 Record Keeping);
4. Must be signed by the LMHP or physician responsible for developing the plan; and
5. Specify a timeline for re-evaluation of the plan that is, at least, an annual redetermination.

The re-evaluation must involve the individual, family and providers and must determine whether services have contributed to meeting the stated goals. The treatment plan must be updated and revised if there is no measureable reduction of disability or restoration of functional level. The updated plan must identify different rehabilitation strategies with revised goals and services. If the services are being provided to a youth enrolled in the Coordinated System of Care (CSoc) program, the wrap-around agency (WAA) must be notified, and the substance use treatment 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.

Treatment Services

Treatment services include:

1. The administration and dispensing of medications;
2. Treatment phases 1 through 4:
 - a. Initial treatment phase lasts from three to seven days. During this phase, the provider conducts orientation, provides individual counseling, and

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- develops the initial treatment plan for treatment of critical health or social issues.
- b. Early stabilization begins on the third to seventh day following initial treatment through 90 days in duration, whereas the provider:
 - i. Conducts weekly monitoring of the member’s response to medication;
 - ii. Provides at least four individual counseling sessions;
 - iii. Revises the treatment plan within 30 days to include input by all disciplines, the member, and significant others; and
 - iv. Conducts random monthly drug screen tests.
 - 3. Maintenance treatment follows the end of early stabilization and lasts for an indefinite period of time. The provider must:
 - a. Perform random monthly drug screen tests until the member has negative drug screen tests for 90 consecutive days as well as random testing for alcohol when indicated;
 - b. Thereafter, monthly testing to members who are allowed six days of take-home doses, as well as random testing for alcohol when indicated;
 - c. Continuous evaluation by the nurse of the member’s use of medication and treatment from the program and from other sources;
 - d. Documented reviews of the treatment plan every 90 days in the first two years of treatment by the treatment team;
 - e. Documentation of response to treatment in a progress note at least every 30 days; and
 - f. Medically supervised withdrawal from synthetic narcotic with continuing care (only when withdrawal is requested by the member). The provider must:
 - i. Decrease the dose of the synthetic narcotic to accomplish gradual, but complete withdrawal, as medically tolerated by member;

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- ii. Provide counseling of the type and quantity based on medical necessity; and
 - iii. Conduct discharge planning as appropriate.
 - 4. Take home dosing:
 - a. Participants may receive take-home doses in accordance with state and federal regulations and the member’s treatment plan phase. Take home dosing is a privilege contingent upon the member’s progress in treatment and surroundings absent of criminal activity and based upon the probability of the member’s risk of diversion, which is determined by assessment and clinical judgement; and
 - b. Guidelines for take home medication privilege:
 - i. Negative drug/alcohol screen for at least 30 days;
 - ii. Regular clinic attendance;
 - iii. Absence of serious behavioral problems and criminal activity during treatment;
 - iv. Stability of home environment and social relationships; and
 - v. Assurance that take-home medication can be safely stored (lock boxes provided by member).
 - 5. Standard schedule:
 - a. After the first 30 days and during the remainder of the first 90 days in treatment, one therapeutic privileged dose per week may be allowed (days 30-90);
 - b. In the second 90 days, two therapeutic doses per week may be allowed (days 91-180);
 - c. In the third 90 days of treatment, three therapeutic doses per week may be allowed;
 - d. In the final 90 days of treatment of the first year, four therapeutic doses per week may be allowed;

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- e. After one year in treatment, a six-day dose supply, consisting of take-home doses and therapeutic doses, may be allowed once a week if the treatment team and medical director determine that the therapeutic privileged doses are appropriate; and
 - f. After two years in treatment, a 13-day dose supply, consisting of take-home doses and therapeutic doses, may be allowed once every two weeks if the treatment team and medical director determine that the therapeutic privileged doses are appropriate.
6. Exceptions:
- a. When the OTP is closed for a legal holiday or Sunday, a take-home dose may be dispensed to members who have attended the clinic at least two times and who have been determined by the nurse to be physically stable and by the counselor to create a minimal risk for diversion; and
 - b. In the event of a Governor’s Declaration of Emergency, emergency provisions for take-home dosing may be enacted, as approved by the State Opioid Treatment Authority (SOTA).
7. Loss of take home privilege:
- a. Positive drug screens at any time for any drug other than prescribed will require a new determination to be made by the treatment team regarding take-home privileges; and
 - b. If the member has a urine drug screen with any substances other than Methadone, Methadone Metabolites, or a medication that the member does not have a valid prescription for, then take-home doses may be eliminated, and the member would then present to the provider’s office in person.
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 must occur, as needed, to achieve the treatment goals. All coordination must be documented in the member’s treatment record.

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Eligibility Criteria

The medical necessity for substance use services must be determined by and recommended by a physician. Members who meet clinical criteria must be at least 18 years old, unless the member has consent from a parent or legal guardian, if applicable, and the SOTA. Members must also meet member admission criteria for federal opioid treatment standards in accordance with 42 CFR [§ 8.12](#), as determined by a physician.

Member Records

In addition to the general requirements for record keeping (refer to Section 2.6), each member's record must contain the following:

1. Recording of medication administration and dispensing in accordance with federal and state requirements;
2. Results of five most recent drug screen tests with action taken for positive results;
3. Physical status and use of additional prescription medication;
4. Contact notes and progress notes (monthly, or more frequently, as indicated by needs of client) that include employment/vocational needs, legal and social status, and overall individual stability;
5. Documentation and confirmation of the factors to be considered in determining whether a take-home dose is appropriate;
6. Documentation of approval of any exception to the standard schedule of take-home doses and the physician's justification for such exception; and
7. Any other pertinent information.

Additional Provider Responsibilities

OTPs must maintain an up-to-date disaster and emergency plan, which has been approved by the SOTA. In the event of an emergency leading to temporary closure of a program, an up-to-date plan for emergency administration of medications must be addressed. OTPs should have the capability to respond to emergencies on a 24-hour basis. The plan should include a contracted physician whom the provider can contact during emergencies. The plan should also include a mechanism for informing members of emergency arrangements and alternative dosing locations and a procedure for notifying SAMHSA, DEA, and state authorities of the event.

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OTPs must coordinate access to the Methadone Central Registry (MCR) for employees who provide direct member care. Access should be coordinated through an email request to the SOTA. The OTP should assign access to more than one person to update the MCR. Updates should occur on a daily basis and/or as changes in prescribed doses occur.

Monthly census and capacity reports must be submitted to the SOTA by the fifth of each month using appropriate documentation format as approved by the SOTA.

Upon the death of a member, the OTP must:

1. Report the death of a member enrolled in its clinic to the SOTA within 24 hours of the discovery of the member's death;
2. Report the death of a member to the Health Standards Section (HSS) within 24 hours of discovery if the death is related to program activity;
3. Submit documentation on the cause and/or circumstances to SOTA and to HSS, if applicable, within 24 hours of the provider's receipt of the documentation; and
4. Adhere to all protocols established by LDH on the death of a member.

Guest dosing occurs when a member receives Methadone dosing at another OTP other than their primary/home based OTP clinic. Guest dosing can be coordinated with the SOTA during natural disasters if the prescriber is unable to contact the provider with whom the member is affiliated. The providers involved in a temporary transfer or guest dosing must ensure the following:

1. The receiving provider must verify dosage prior to dispensing and administering medication;
2. The sending provider must verify dosage and obtain approval and acceptance from receiving provider prior to member's transfer; and
3. Documentation to support all temporary transfers and guest dosing is maintained.

NOTE: Non-preferred forms of buprenorphine and buprenorphine/naloxone require prior authorization.

Services provided to adolescents must include communication and coordination with the family and/or legal guardian. Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the youth's medical record.

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All substance use treatment services must offer the family component. Adolescent substance use programs must include family involvement, parent education, and family therapy.

Staffing for the facility must be consistent with State licensure regulations on a full-time employee (FTE) basis.

Provider Qualifications**Agency**

To provide services, OTPs must meet the following requirements:

1. Licensed by the Louisiana Department of Health (LDH) per La. R.S. 40:2151 et seq.;
2. OTPs must be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or The Joint Commission (TJC). Denial, loss of, or any negative change in accreditation status must be reported in writing immediately upon notification to the managed care entities with which the agency contracts or is being reimbursed;
3. Services must be provided under the supervision of a licensed mental health professional (LMHP) or physician who is acting within the scope of their professional license and applicable state law. (Refer to Appendices B and D for more information on LMHPs). The term supervision refers to clinical support, guidance, and consultation afforded to unlicensed staff, and should not be confused with clinical supervision of bachelor's or master's level individuals or provisionally licensed individuals pursuing licensure. Such individuals must comply with current, applicable scope of practice and supervisory requirements identified by their respective licensing boards;
4. Arrange for and maintain 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:
 - a. 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 unlicensed direct care staff;

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- b. La. R.S. 40:1203.1 et seq. associated with criminal background checks of un-licensed workers providing member care;
 - c. La. R.S. 15:587, as applicable; and
 - d. Any other applicable state or federal law.
5. Providers must not hire individuals failing to meet criminal background check requirements and regulations. Individuals not in compliance with criminal background check requirements and regulations must 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;
6. 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 with 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;
7. 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>;
8. Arrange for and maintain documentation that all persons, prior to employment, are free from Tuberculosis (TB) in a communicable state via skin testing (or chest exam if recommended by physician) to reduce the risk of such infections in members and staff. Results from testing performed over 30 days prior to date of employment will not be accepted as meeting this requirement;

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9. Establish and maintain written policies and procedures inclusive of drug testing staff to ensure an alcohol and drug-free workplace and a workforce free of substance use. (Refer to Appendix D);
10. Maintain documentation that all direct-care staff who are required to complete First Aid, cardiopulmonary resuscitation (CPR), and seizure assessment training, complete American Heart Association (AHA) recognized training, within 90 days of hire, which must be renewed within a time period recommended by the AHA. (Refer to Appendices A and D);
11. Maintain documentation of verification of staff meeting educational and professional requirements and licensure (where applicable), as well as completion of required trainings for all staff. Quarterly trainings must be documented and submitted to the SOTA on a quarterly basis; and
12. Ensure and maintain documentation that all unlicensed persons employed by the organization complete training in a recognized crisis intervention (CI) curriculum prior to handling or managing crisis calls, which must be updated annually.

Staff

To provide services, staff must meet the following requirements:

1. Licensed and unlicensed professional staff must be at least 18 years of age, have a high school diploma or equivalent according to the areas of competence as determined by degree, and have the required levels of experience as defined by State law and regulations and departmentally approved guidelines and certifications;
2. Effective six (6) months after publication date, staff must be at least three years older than any member served under 18 years of age. Licensed individual practitioners with no documentation of having provided substance use services prior to December 1, 2015, are required to demonstrate competency via the Alcohol and Drug Counselor (ADC) exam, the Advanced Alcohol and Drug Counselor (AADC) exam, or the Examination for Master Addictions Counselor (EMAC). Any licensed individual practitioner who has documentation of providing substance use services prior to December 1, 2015, and within the scope of practice, is exempt from (ADC, AADC, EMAC) testing requirements. Organizational agencies are required to obtain verification of competency (passing of accepted examinations) or exemption (prior work history/resume, employer letter);

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3. Staff can include the Office of Behavioral Health (OBH) credentialed peer support specialists who meet all other qualifications. A peer specialist is a recommended position at all ASAM levels of care. A peer specialist is a person with lived experience with behavioral health challenges, who is in active recovery, and who is trained to assist others in their own recovery. The peer specialist uses their own unique, life-altering experience in order to guide and support others who are in recovery. This refers to individuals recovering from substance use disorders. Peer specialists work in conjunction with highly trained and educated professionals. They fill a gap by providing support from the perspective of someone who has first-hand experience;
4. The provider is prohibited from knowingly employing or contracting with, or retaining the employment of or contract with, a member of the direct care staff who has an alcohol or drug offense, unless the employee or contractor has completed their court-ordered sentence, including community service, probation, and/or parole and been sober per personal attestation for at least the prior two years;
5. Satisfactory completion of criminal background checks 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;
6. Pass a TB test prior to employment;
7. Pass drug screening tests as required by agency’s policies and procedures;
8. 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;
9. Direct care staff must not have a finding on the Louisiana State Adverse Action List;
10. Complete AHA recognized First Aid, CPR and seizure assessment training. Psychiatrists, advanced practical registered nurses (APRNs)/clinical nurse specialists (CNSs)/physician assistants (PAs), registered nurses (RNs), and licensed practical nurses (LPNs) are exempt from this training. (Refer to Appendix D);
11. All direct care staff must receive orientation and training for and demonstrate knowledge of the following, including, but not limited to:
 - a. Symptoms of opiate withdrawal;

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- b. Drug screen testing and collections;
 - c. Current standards of practice regarding opiate addiction treatment;
 - d. Poly-drug addiction; and
 - e. Information necessary to ensure care is provided within accepted standards of practice.
12. Non-licensed direct care staff are required to complete a basic clinical competency training program approved by OBH prior to providing the service. (Refer to Appendix D).

Staffing Requirements

Personnel must consist of professional and other support staff that are adequate to meet the needs of the individuals admitted to the facility.

The OTP must have the following staff:

Medical Director

The provider must ensure that its medical director is a licensed physician with a current, valid unrestricted license to practice in the state of Louisiana with two years of qualifying experience in treating psychiatric disorders.

The medical director must provide the following services:

- 1. Decrease the dose to accomplish gradual, but complete withdrawal, only when requested by the member;
- 2. Provide medically approved and medically supervised assistance for withdrawal, only when requested by the member;
- 3. Participate in the documentation of reviews of treatment plan every 90 days in the first two years of treatment;
- 4. Order take-home doses; and
- 5. Participate in discharge planning.

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Pharmacist or Dispensing Physician

The OTP must employ or contract with a pharmacist or dispensing physician to assure that any prescription medication dispensed on-site meets the requirements of applicable state statutes and regulations. The pharmacist or dispensing physician must have a current, valid unrestricted license to practice in the state of Louisiana and provide the following services:

1. Dispense all medications;
2. Work collaboratively with the Medical Director to decrease the dose to accomplish gradual, but complete withdrawal, only when requested by the member;
3. Contribute to the development of the initial treatment plan;
4. Contribute to the documentation for the treatment plan review every 90 days in the first two years of treatment; and
5. Document response to treatment in progress notes at least every 30 days.

Clinical Supervisor

State regulations require supervision of unlicensed professionals by a clinical supervisor, who:

1. Is an LMHP that maintains a current and unrestricted license with its respective professional board or licensing authority in the state of Louisiana;
2. Must be on duty and on call as needed;
3. Has two years of qualifying clinical experience as an LMHP in the provision of services provided by the provider; and
4. Must have the following responsibilities:
 - a. Provide supervision utilizing evidenced-based techniques related to the practice of behavioral health counseling;
 - b. Serve as a resource person for other professionals counseling persons with behavioral health disorders;

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- c. Attend and participate in care conferences, treatment planning activities, and discharge planning;
- d. Provide oversight and supervision of such activities as recreation, art/music, or vocational education;
- e. Function as member advocate in treatment decisions;
- f. Ensure the provider adheres to rules and regulations regarding all behavioral health treatment, such as group size, caseload, and referrals;
- g. Provide only those services that are within the person’s scope of practice; and
- h. Assist the clinical director and/or medical director and governing body with the development and implementation of policies and procedures.

Physician or APRN

The physician or APRN must have a current, valid unrestricted license to practice in the state of Louisiana. The physician or APRN must be on-site as needed or on-call as needed during the hours of operations to provide the following services:

- 1. Examine member for admission (physician only);
- 2. Administer medications;
- 3. Monitor the member’s response to medications;
- 4. Evaluate of member’s use of medication and treatment from the program and other sources;
- 5. Contribute to the development of the initial treatment plan;
- 6. Contribute to the documentation regarding the response to treatment for treatment plan reviews;
- 7. Contribute to the documentation for the treatment plan review every 90 days in the first two years of treatment;
- 8. Conduct drug screens; and

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9. Participate in discharge planning.

Nursing Staff

Nursing staff must have a current, valid, and unrestricted nursing license in the State of Louisiana and provide the following services:

1. Administer medications;
2. Monitor the member’s response to medications;
3. Evaluate of member’s use of medication and treatment from the program and other sources;
4. Document response to treatment in progress notes at least every 30 days;
5. Contribute to documentation for the treatment plan review every 90 days in the first two years of treatment;
6. Conduct drug screens; and
7. Participate in discharge planning.

Licensed Mental Health Professional (LMHP)

Licensed Mental Health Professionals (LMHPs) must have a current, valid, and unrestricted license in the State of Louisiana, and must comply with current, applicable scope of practice and supervisory requirements identified by their respective licensing boards. The LMHP providing substance use treatment services must have documented credentials, experience, and/or training in working with members who have substance use disorders, which must be maintained in the individual’s personnel record.

LMHPs provide the following services:

1. Conduct orientation;
2. Develop the initial plan for treatment;
3. Revise treatment to include input by all disciplines, members, and significant others;

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4. Provide individual counseling;
5. Contribute to the development of as well as document the initial treatment plan;
6. Document response to treatment in progress notes at least every 30 days;
7. Contribute to the development of as well as document reviews of treatment plan every 90 days in the first two years of treatment by the treatment team; and
8. Conduct in discharge planning as appropriate.

Unlicensed professionals (UPs)

Unlicensed professionals (UPs) of substance use services must be registered with the Addictive Disorders Regulatory Authority (ADRA) and meet regulations and requirements in accordance with La. R.S. 37:3387 et seq. Written verification of ADRA registration and documentation of supervision when applicable must be maintained in the individual’s personnel record. Unlicensed staff who fall under a professional scope of behavioral health practice with formal board approved clinical supervision and whose scope includes the provision of substance use services will not need to register with ADRA. Unlicensed substance use providers must meet at least one of the following qualifications:

1. Be a master’s-prepared behavioral health professional that has not obtained full licensure privileges and is participating in ongoing professional supervision. When working in substance use treatment settings, the master’s-prepared UP must be supervised by an LMHP, who meets the requirements of this Section;
2. Be a registered addiction counselor;
3. Be a certified addiction counselor; or
4. Be a counselor-in-training (CIT) that is registered with ADRA and is currently participating in a supervision required by the Addictive Disorders practice act.

Unlicensed professionals perform the following services under the supervision of a physician or LMHP:

1. Participate in conducting orientation;
2. Participate in discharge planning as appropriate; and

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3. Provide support to the treatment team where applicable, while only providing assistance allowable under the auspices of and pursuant to the scope of the individual’s license.

Staff Ratios

OTPs must maintain a sufficient level of staffing to meet the needs of the members. The caseload of each LMHP or UP must not exceed 75 active members.

Allowed Provider Types and Specialties

PT 68 Substance Use and Alcohol Use Center PS 70 Clinic/Group with Subspecialty 8V Methadone Clinic.

Allowed Modes of Delivery

1. Individual;
2. Group;
3. On-site; and
4. Tele-video (LMHPs only).

Telehealth

LMHP’s providing assessments, evaluations, individual psychotherapy, family psychotherapy, and medication management services offered within Opioid treatment programs may be reimbursed when conducted via telecommunication technology. The LMHP is responsible for acting within the telehealth scope of practice as decided by the respective licensing board. The provider must bill the procedure code (CPT codes) with modifier “95”, as well as the correct place of service, either POS 02 (other than home) or 10 (home). Reimbursement will be at the same rate as a face-to-face service.

Exclusions: Methadone admission visits conducted by the admitting physician within OTPs are not allowed via telecommunication technology.

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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.

<i>Code</i>	<i>Explanation of Benefits</i>
H0020	<p>Methadone Bundled Rate Bundled rate includes all state and federal regulatory mandated components of treatment. Services include but are not limited to the following:</p> <ol style="list-style-type: none"> 1. Medication: This includes the administration, dosing, and dispensing of Methadone as per the member’s treatment plan; 2. Counseling: Members are required to participate in group or individual sessions as part of the member’s treatment plan; 3. Urine drug testing: This includes the urine drug testing or other laboratory tests deemed medically necessary; 4. Physical examinations by a physician or advanced practice registered nurse; 5. Evaluation and management visits; 6. Care coordination; and 7. Laboratory services. <p>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.</p> <p>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 MCR to ensure correct dosing.</p>

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H0047	<p>Buprenorphine Bundled Rate Bundled rate includes all components of treatment, except for the Buprenorphine medication. Services include, but are not limited to, the following:</p> <ol style="list-style-type: none">1. Assessment and individualized treatment plan;2. Individual and group counseling;3. Urine drug testing or laboratory testing; and4. Coordination of medically necessary services. <p>Buprenorphine medication will be billed separately using the applicable J-codes (J0571-J0575) depending on dosage amounts.</p>
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Coordinated System of Care

The Coordinated System of Care (CSoC) is an innovative reflection of two powerful movements in health care: coordination of care for individuals with complex needs and family-driven and youth-guided care. CSOC is guided by an overarching System of Care (SOC) philosophy and values which include: family driven, youth guided, home and community based, strengths based, individualized, culturally and linguistically competent, integration across systems, connection to natural supports, data driven and outcomes oriented and unconditional care. The Louisiana CSOC uses a wraparound approach to create and oversee a service delivery system that is better integrated, has enhanced service offerings and achieves improved outcomes by ensuring families who have children with severe behavioral health challenges get the right support and services, at the right level of intensity, at the right time, for the right amount of time, from the right provider, to ultimately keep or return children home or to their home communities. Combining all services into one coordinated plan allows for better communication and collaboration among families, youth, state agencies, providers and others who support the family.

Once enrolled in CSOC, children, youth and families work with wraparound facilitators, employed by the Wraparound Agency, who are trained in the wraparound model, which is a structured, four phase, creative, and individualized planning process, guided by the SOC values and principles. In addition to wraparound facilitation children, youth and families have access to four specialized services in addition to other medically necessary state plan services. For more information about the program visit the CSOC website, www.csoc.la.gov.

Services

There are four specialized services available to youth enrolled in the CSOC program in addition to other medically necessary state plan services. Each CSOC service is described in more detail in the next section:

1. Parent Support and Training;
2. Youth Support and Training;
3. Short-Term Respite; and
4. Independent Living/Skills Building.

Service Limitations

The following services shall be excluded from Medicaid reimbursement:

1. Components that are not provided to, or directed exclusively toward the treatment of, the Medicaid eligible individual;
2. Services provided at a work site which are job tasks oriented and not directly related to the treatment of the member’s needs;
3. Services or components in which the basic nature of which are to supplant housekeeping, homemaking, or basic services for the convenience of an individual receiving services;
4. Services rendered in an institution for mental disease; and
5. Services rendered in a setting that does not meet the characteristics of a home and community based setting according to standards established by the Center for Medicare and Medicaid Services.

Eligibility

Children, youth and families eligible for CSoC include Medicaid members between the ages of 5 and 20 years of age, who have a severe emotional disturbance (SED) or a serious mental illness (SMI) and who are in or at risk of out of home placement.

Parent Support and Training

Person- and family-centered care involves peer- and family-support services. The widespread adoption of peer services has led to greater deployment across services for both physical and behavioral health. Peer-support services are provided in a variety of settings and across different models of care. Peer-support services are services designed and delivered by individuals who have experienced a mental or substance use disorder and are in recovery. They also include services designed and delivered by family members of those in recovery. Peer specialists foster hope and promote a belief in the possibility of recovery. (See www.samhsa.gov/section-223/care-coordination/person-family-centered).

Research has shown that peer-support services can reduce symptoms and hospitalizations; increase social support and participation in the community; decrease lengths of hospital stays and costs of

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services; improve well-being, self-esteem and social functioning; and, encourage more thorough and longer-lasting recoveries. (See www.mentalhealthamerica.net/peer-services).

Parent Support and Training (PST) is designed to benefit the parent/primary caregiver of a Medicaid-eligible child/youth experiencing a SED who is eligible for the CSoC and is at risk of out-of-home placement. This service provides the training and support necessary to ensure engagement and active participation of the family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. The specialist may attend meetings with the family and assist in helping family members to effectively contribute to planning and accessing services, including assistance with removing barriers. The specialist assists in describing the program model and providing information, as needed, to assist the family. Support and training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the child/youth (e.g., parenting children with various behavior challenges). **These activities may not be delivered in the provider's place of residence.**

Components

This involves the following:

1. Assisting the family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the eligible child/youth in relation to their mental illness/addictive disorder and treatment; development and enhancement of the family's specific problem-solving skills, coping mechanisms and strategies for the child's/youth's symptom/behavior management;
2. Assisting the family in understanding various requirements of the waiver process, such as the crisis/safety plan and plan of care (POC) process;
3. Training on understanding the child's diagnoses;
4. Understanding service options offered by service providers and assisting with understanding policies, procedures and regulations that impact the child with mental illness/addictive disorder concerns while living in the community (e.g., training on system navigation and Medicaid interaction with other child-serving systems); and
5. The specialist may also conduct follow-up with the families regarding services provided and continuing needs.

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For the purpose of the CSoC, family is defined as the primary care-giving unit and is inclusive of the wide diversity of primary care-giving units in our culture. Family is a biological, adoptive or self-created unit of people residing together, consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood for the child(ren). Persons within this unit share bonds, culture, practices and a significant relationship. Biological parents, siblings and others with significant attachment to the individual living outside the home are included in the definition of family. For the purposes of this service, "family" is defined as the persons who live with, or provide care to, a person served on the waiver and may include a parent, spouse, sibling, children, relatives, grandparents, guardians, foster parents or others with significant attachment to the individual. Services may be provided individually or in a group setting.

Provider Qualifications

Family Support Organization

Certification by the CSoC Contractor as a Family Support Organization (FSO), which includes documentation of the following:

1. A licensed mental health professional (LMHP) shall be available at all times to provide back up, support and/or consultation. (See Appendix D);

2. Arranges for and maintains documentation that all persons, prior to employment, pass drug screen and 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 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. Drug screens and criminal background checks performed over 30 days prior to date of employment will not be accepted as meeting this requirement;

3. The provider must review the Department of Health and Human Services' Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) and

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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;

4. 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>;

5. Arranges for and maintains documentation that all persons, prior to employment, are free from Tuberculosis (TB) in a communicable state via skin testing (or chest exam if recommended by physician) to reduce the risk of such infections in members and staff. Results from testing performed over 30 days prior to date of employment will not be accepted as meeting this requirement;

6. Establishes and maintains written policies and procedures inclusive of drug testing staff to ensure an alcohol and drug-free workplace and a workforce free of substance use. (See Appendix D);

7. Maintains documentation that all direct care staff, who are required to complete First Aid, cardiopulmonary resuscitation (CPR) and seizure assessment training, complete American Heart Association (AHA) recognized training within 90 days of hire, which shall be renewed within a time period recommended by the AHA. (See Appendix D);

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8. Maintains documentation, including frequency and type of activity, that individual staff members have completed required PST training prior to rendering PST services to members and/or supervising Parent Support Specialists. The FSO supervisors and direct care staff are required to complete the following trainings: Introduction to Wraparound for Family Support Specialists, Functional Behavioral Approach as well as any additional training required by OBH. These specialized trainings ensure that the direct care staff has the knowledge base needed to provide information and support to the families that they work with. These trainings also focus on skill development, so that the parent support and youth support specialists will be able to use their personal experiences to engage families;
9. Ensures and maintains documentation that all unlicensed persons employed by the organization complete training in a recognized Crisis Intervention curriculum prior to handling or managing crisis calls, which shall be updated annually;
10. Maintains documentation of verification of completion of required trainings for all staff; and
11. Each Family Support Organization 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 OBH-CSoC.

Parent Support Specialist

1. High school diploma or equivalent;
2. Must be at least 21 years of age and have a minimum of two years' experience living or working with a child with SED or SMI (youth over the age of 18), or be equivalently qualified by education in the human services field (See Appendix B) or a combination of life/work experience and education, with one year of education substituting for one year of experience (preference is given to parents or caregivers of children with SED/SMI);
3. Successful completion of parent support training, according to a curriculum approved by OBH, prior to providing the service. (See Appendix D);

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4. Completion of continuing education in confidentiality requirements, Health Insurance Portability and Accountability Act (HIPAA) requirements and mandated reporting;
5. 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;
6. 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;
7. Direct care staff must not have a finding on the Louisiana State Adverse Action List;
8. Pass a motor vehicle screen;
9. Pass a TB test prior to employment;
10. Pass drug screening tests as required by agency's policies and procedures;
11. Complete AHA recognized First Aid, CPR and seizure assessment training. Psychiatrists, advanced practical registered nurses (APRNs)/clinical nurse specialist (CNSs)/physician assistants (PAs), registered nurses (RNs) and licensed practical nurses (LPNs) are exempt from this training. (See Appendix D); and
12. Non-licensed direct care staff are required to complete a basic clinical competency training program approved by OBH prior to providing the service. (See Appendix D).

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Parent Support Supervisor

1. Minimum of a bachelor’s degree in a human services field or bachelor’s degree in any field with a minimum of two years of full-time experience working in relevant family, children/youth or community service capacity;
2. Successful completion of PST Supervisor training; and
3. Meet the above qualifications for a Parent Support Specialist.

Allowed Provider Types and Specialties

PT AC FSO, PS 5L Youth and Family Support, PSS 8E CSoC/Behavioral Health.

Limitations and Exclusions

1. PST specialist supervisor (1:80 youth). Adjustments to ratios may be granted on a case by case basis with OBH’s approval;
2. PST specialist (1:20 youth). Adjustments to ratios may be granted on a case by case basis with OBH’s approval;
3. Parent support and training will not duplicate any other Medicaid State Plan service or other services otherwise available to the member at no cost (e.g., provided as charity care);
4. Local Education Agencies (LEAs) may not provide this service; and
5. PST must address the needs identified in the assessment and goals/objectives identified in the member’s individualized POC.

Allowed Mode(s) of Delivery

1. Family;
2. Group;
3. On-site; and

4. Off-site.

Additional Service Criteria

1. One full-time employee (FTE) to 10 families is maximum group size;
2. Parent trainer/group facilitators (one FTE per 160 families, minimum staffing ratio);
3. Services provided to children and youth must include communication and coordination with the family and/or legal guardian, including any agency legally responsible for the care or custody of the child. Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the youth’s treatment record. Time spent in coordination activities is not billable time. However, there is a cost factor for coordination built into the rates;
4. The parent support specialist must be supervised by a person meeting the qualifications for a parent support supervisor and an LMHP;
5. The individuals performing the functions of the parent support specialist may be full-time or part-time; and
6. PST may be provided concurrently with the development of the POC.

Youth Support and Training

Youth Support and Training (YST) services are child-/youth-centered services that provide the training and support necessary to ensure engagement and active participation of the youth in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. YST is best delivered to members who have the capacity and ability to understand their diagnosis and symptoms and to be an active participant in their treatment decisions. The Youth support and training services will have a recovery focus designed to promote skills for coping with and managing psychiatric symptoms while facilitating the utilization of natural resources and the enhancement of community living skills.

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Activities included must be intended to achieve the identified goals or objectives as set forth in the child /youth’s individualized POC. The structured, scheduled activities provided by this service emphasize the opportunity for youth to support other children and youth in the restoration and expansion of the skills and strategies necessary to move forward in recovery. YST is an intervention with the child/youth present. Services can be provided individually or in a group setting. The majority of YST contacts must occur in community locations where the person lives, works, attends school and/or socializes. **These activities may not be delivered in the provider’s place of residence.**

Components

1. Helping the child/youth to develop a network for information and support from others who have been through similar experiences;
2. Assisting the child/youth to regain the ability to make independent choices and take a proactive role in treatment, including discussing questions or concerns with their clinician about medications, diagnoses or treatment;
3. Assisting the child/youth to identify, and effectively respond to or avoid, identified precursors or triggers that maintain or increase functional impairments; and
4. Assisting the child/youth with the ability to address and reduce the following behaviors, reducing reliance on YST over time: rebellious behavior, early initiation of antisocial behavior (e.g., early initiation of drug use, shoplifting, truancy), attitudes favorable toward drug use (including perceived risks of drug use), antisocial behaviors toward peers, contact with friends who use drugs, gang involvement and intentions to use drugs.

Provider Qualifications

Family Support Organization

Certification by the CSoC Contractor as a FSO, which includes documentation of the following:

1. A LMHP shall be available at all times to provide back up, support and/or consultation. (See Appendix D);
2. Arranges for and maintains documentation that all persons, prior to employment, pass drug screen and criminal background checks through the Louisiana

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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 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. Drug screens and criminal background checks performed over 30 days prior to date of employment will not be accepted as meeting this requirement;

3. 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;
4. 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>;
5. Arranges for and maintains documentation that all persons, prior to employment, are free from TB in a communicable state via skin testing (or chest exam if recommended by physician) to reduce the risk of such infections in members and

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staff. Results from testing performed over 30 days prior to date of employment will not be accepted as meeting this requirement;

6. Establishes and maintains written policies and procedures inclusive of drug testing staff to ensure an alcohol and drug-free workplace and a workforce free of substance use. (See Appendix D);
7. Maintains documentation that all direct care staff, who are required to complete First Aid, CPR and seizure assessment training, complete AHA recognized training within 90 days of hire, which shall be renewed within a time period recommended by the AHA. (See Appendix D);
8. Maintains documentation, including frequency and type of activity, that individual staff members have completed required YST training prior to rendering YST services to members. The FSO supervisors and direct care staff are required to complete the following trainings: Introduction to Wraparound for Family Support Specialists, Functional Behavioral Approach as well as any additional training required by OBH. These specialized trainings ensure that the direct care staff has the knowledge base needed to provide information and support to the families that they work with. These trainings also focus on skill development, so that the parent support and youth support specialists will be able to use their personal experiences to engage families;
9. Each Family Support Organization 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 OBH-CSoC;
10. Ensures and maintains documentation that all unlicensed persons employed by the organization complete training in a recognized Crisis Intervention curriculum prior to handling or managing crisis calls, which shall be updated annually; and
11. Maintains documentation of verification of completion of required trainings for all staff.

Youth Support Specialist

1. High school diploma or equivalent, or must be currently seeking diploma;

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2. Must be at least 18 years of age and self-identify as a present or former child member of behavioral health services;
3. Successful completion of youth support training, according to a curriculum approved by OBH, prior to providing the service. (See Appendix D);
4. Completion of continuing education in confidentiality requirements, Health Insurance Portability and Accountability Act (HIPAA) requirements and mandated reporting;
5. 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;
6. 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;
7. Direct care staff must not have a finding on the Louisiana State Adverse Action List;
8. Pass drug screening tests as required by agency's policies and procedures;
9. Pass a motor vehicle screen;
10. Pass a TB test prior to employment;
11. Complete AHA recognized First Aid, CPR and seizure assessment training. Psychiatrists, APRNs/CNSs/PAs, RNs and LPNs are exempt from this training (See Appendix D); and

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12. Non-licensed direct care staff are required to complete a basic clinical competency training program approved by OBH prior to providing the service. (See Appendix D).

Youth Support Supervisor

1. Minimum of a bachelor's degree in a human services field or bachelor's degree in any field with a minimum of two years of full-time experience working in relevant family, children/youth or community service capacity;
2. Successful completion of YST Supervisor training; and
3. Meet the above qualifications for a Youth Support Specialist.

Allowed Provider Types and Specialties

1. PT AC FSO, PS 5L Youth and Family Support, PSS 8E CSoC/Behavioral Health.

Limitations and Exclusions

1. YST specialist supervisor (1:80 youth). Adjustments to ratios may be granted on a case by case basis with OBH's approval;
2. YST specialist (1:20 youth). Adjustments to ratios may be granted on a case by case basis with OBH's approval;
3. Youth support and training will not duplicate any other Medicaid State Plan service or other services otherwise available to the member at no cost (e.g., provided as charity care);
4. YST must address the needs identified in the assessment and goals/objectives identified in the member's individualized POC;
5. Local Education Agencies (LEAs) may not provide this service; and

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6. Limit of 750 hours of YST per calendar year. This limit can be exceeded when medically necessary in conjunction with an approved plan of care developed by the Child and Family Team.

Allowed Mode(s) of Delivery

1. Individual;
2. Group;
3. On-site; and
4. Off-site.

Additional Service Criteria

1. Services provided to children and youth must include communication and coordination with the family and/or legal guardian, including any agency legally responsible for the care or custody of the child;
2. Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the youth’s treatment record. Time spent in coordination activities is not billable time. However, there is a factor for coordination built into the rates;
3. The YST specialist must be supervised by a person meeting the qualifications for a YST supervisor and an LMHP; and
4. YST may be provided concurrently with the development of the POC.

Independent Living/Skills Building

Independent living/skills building services are designed to assist children who are, or will be, transitioning to adulthood beginning at the age of 14 years old with support in acquiring, retaining and improving self-help, socialization and adaptive skills necessary to be successful in the domains of employment, housing, education and community life and to reside successfully in home and community settings. Independent living/skills building activities are provided in partnership with young children to help the child/youth arrange for the services they need to become employed,

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access transportation, housing and continuing education. Services are individualized according to each youth’s strengths, interests, skills, goals and are included on an individualized transition plan (i.e., waiver POC).

It is expected that independent living/skills building activities take place in the community. **These activities may not be delivered in the provider’s place of residence.** This service can be utilized to train and cue normal activities of daily living and instrumental activities of daily living. Housekeeping, homemaking (shopping, child care and laundry services) or basic services, solely for the convenience of a child receiving independent living/skills building, are not covered. An example of community settings could encompass: a grocery or clothing store,(teaching the young person how to shop for food, or what type of clothing is appropriate for interviews), unemployment office (assist in seeking jobs, assisting the youth in completing applications for jobs), apartment complexes (to seek out housing opportunities), laundromats (how to wash their clothes). Additional life skills training examples include life safety skills, ability to access emergency services, basic safety practices and evacuation, physical and mental health care (maintenance, scheduling physician appointments), recognizing when to contact a physician, self-administration of medication for physical and mental health conditions, understanding purpose and possible side effects of medication prescribed for conditions, other common prescription and non-prescription drugs and drug uses, use of transportation (accessing public transportation, learning to drive, obtaining insurance), etc. These services may be provided in any other community setting as identified through the POC process. This is not an all-inclusive list.

Transportation provided between the child/youth’s place of residence, other services sites or places in the community, and the cost of transportation is included in the rate paid to providers of this service.

Provider Qualifications

Transition Coordination Agency

To provide transition coordination services, agencies must meet the following criteria:

1. Be licensed per R.S. 40:2151 et seq;
2. 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

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hire an individual with a record as a sex offender nor permit these individuals to work for the provider as a subcontractor;

3. Criminal background checks must be performed as required by R.S. 40:1203 et seq., and in accordance with R.S. 15:587 et seq. Criminal background checks performed over 30 days prior to date of employment will not be accepted as meeting this requirement;
4. 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;
5. 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>;
6. Arranges for and maintains documentation that all persons, prior to employment, are free from TB in a communicable state via skin testing (or chest exam if recommended by physician) to reduce the risk of such infections in members and staff. Results from testing performed over 30 days prior to date of employment will not be accepted as meeting this requirement;

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7. Establishes and maintains written policies and procedures inclusive of drug testing staff to ensure an alcohol and drug-free workplace and a workforce free of substance use. (See Appendix D);
8. Maintains documentation that all direct care staff, who are required to complete First Aid, CPR and seizure assessment training, complete AHA recognized training within 90 days of hire, which shall be renewed within a time period recommended by the AHA. (See Appendix D);
9. Ensures and maintains documentation that all unlicensed persons employed by the organization complete a documented training in a recognized Crisis Intervention curriculum prior to handling or managing crisis calls, which shall be updated annually;
10. Maintains documentation of verification of completion of required trainings for all staff;
11. Ensures supervision is provided to the Transition Coordinator to provide back up, support and/or consultation;
12. Ensures a LMHP is available at all times to provide back up, support and/or consultation. (See Appendix D); and
13. Employs Transition Coordinators with the below qualifications.

Transition Coordinator

1. High school diploma or equivalent;
2. Must be at least 21 years of age and have a minimum of two years' experience working with children with SED or be equivalently qualified by education in the human services field or a combination of work experience and education, with one year of education substituting for one year of experience. (See Appendix B);
3. Pass criminal background check through the Louisiana Department of Public Safety, State Police prior to employment;

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4. 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;
5. Direct care staff must not have a finding on the Louisiana State Adverse Action List;
6. Pass a motor vehicle screen;
7. Pass a TB test prior to employment;
8. Pass drug screening tests as required by agency's policies and procedures;
9. Complete AHA recognized First Aid, CPR and seizure assessment training. Psychiatrists, APRNs/CNSs/PAs, RNs and LPNs are exempt from this training. (See Appendix D); and
10. Non-licensed direct care staff are required to complete a basic clinical competency training program approved by OBH. (See Appendix D). Complete an approved training in the skills area(s) needed by the transitioning youth, according to a curriculum approved by OBH prior to providing the service. (See Appendix D).

Allowed Provider Types and Specialties

1. PT AD Transition Coordination;
2. PS 5U Individual, PSS 8E – CSoC/Behavioral Health; and
3. PS 5V Agency/Business, PSS 8E – CSoC/Behavioral Health.

Limitations and Exclusions

1. Independent living/skills building will not duplicate any other Medicaid State Plan service or other services otherwise available to the member at no cost (e.g., provided as charity care);

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2. Independent living/skills building must address the needs identified in the assessment and address goals/objectives identified in the member’s individualized POC;
3. Local Education Agencies (LEAs) may not provide this service; and
4. Service requires prior authorization.

Allowed Mode(s) of Delivery

1. Individual;
2. On-site; and
3. Off-site.

Additional Service Criteria

Services provided to children and youth must include communication and coordination with the family and/or legal guardian, including any agency legally responsible for the care or custody of the child. Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the youth’s medical record. Time spent in coordination activities is not billable time. However, there is a factor for coordination built into the rates.

Independent living/skills building may be provided concurrently with the development of the POC.

Short-Term Respite Care

Short-term respite care provides temporary direct care and supervision for the child/youth in the child’s home or a community setting that is not facility-based (i.e., not provided overnight in a provider-based facility). The primary purpose is relief to families/caregivers of a child with a SED or relief of the child. The service is designed to help meet the needs of the primary caregiver, as well as the identified child. Respite services help to de-escalate stressful situations and provide a therapeutic outlet for the child. Respite may be either planned or provided on an emergency basis. Normal activities of daily living are considered to be included in the content of the service when providing respite care and cannot be billed separately. These include support in the home, after school or at night, transportation to and from school/medical appointments or other community-based activities and/or any combination of the above. The cost of transportation is also included

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in the rate paid to providers of this service. Short-term respite care can be provided in an individual's home or place of residence or provided in other community settings, such as at a relative's home or in a short visit to a community park or recreation center. The child must be present when providing short-term respite care.

Provider Qualifications

Agency

1. 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 et seq., and in accordance with R.S. 15:587 et seq. Criminal background checks performed over 30 days prior to date of employment will not be accepted as meeting this requirement;
2. Arranges for and maintains documentation that all persons, prior to employment, are free from TB in a communicable state via skin testing (or chest exam if recommended by physician) to reduce the risk of such infections in member and staff. Results from testing performed over 30 days prior to date of employment will not be accepted as meeting this requirement;
3. Establishes and maintains written policies and procedures inclusive of drug testing staff to ensure an alcohol and drug-free workplace and a workforce free of substance use. (See Appendix D);
4. Maintains documentation that all direct care staff, who are required to complete First Aid, CPR and seizure assessment training, complete AHA recognized training within 90 days of hire, which shall be renewed within a time period recommended by the AHA. (See Appendix D);

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5. 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;
6. 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;
7. 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>;
8. Ensures and maintains documentation that all unlicensed persons employed by the organization complete a documented training in a recognized Crisis Intervention curriculum prior to handling or managing crisis calls, which shall be updated annually; and
9. Maintains documentation of verification of completion of required trainings for all staff.

General note on supervision of Direct Service Workers

Per LDH Health Standards Section HCBS Rule, home and community based agencies must supervise the direct service workers (DSWs) that provide the care members receive. The requirement is for the supervisor of the DSW to make an onsite visit to the member’s home to evaluate the following:

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1. The DSW’s ability to perform their assigned duties;
2. To determine whether member is receiving the services that are written in the plan of care;
3. To verify that the DSW is actually reporting to the home according to the frequency ordered in the plan of care; and
4. To determine member satisfaction with the services member is receiving.

Staff

The following individual qualifications are required for the direct care staff person:

1. Must be at least 18 years of age, and at least three years older than an individual under the age of 18;
2. High school diploma, general equivalency diploma or trade school diploma in the area of human services (See Appendix B), or demonstrate competency or verifiable work experience in providing support to persons with disabilities;
3. Pass criminal and professional background checks through the Louisiana Department of Public Safety, State Police prior to employment;
4. Pass a TB test prior to employment;
5. Pass drug screen testing as required by agency’s policies and procedures;
6. Complete AHA recognized First Aid, CPR and seizure assessment training. Psychiatrists, APRNs/CNSs/PAs, RNs and LPNs are exempt from this training. (See Appendix D);
7. Pass a motor vehicle screen;

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8. 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;
9. Direct care staff must not have a finding on the Louisiana State Adverse Action List;
10. Possess and provide documentation of a valid social security number;
11. Provide documentation of CPR and first aid certifications;
12. Comply with law established by R.S. 40:2179 et seq., and meet any additional qualifications established under Rule promulgated by LDH in association with this statute; and
13. Completion of The Family Involvement Center's Short Term Respite Provider training curriculum approved by OBH prior to providing the service (See Appendix D).

Allowed Provider Types and Specialties

Respite Care Services Agency

To provide respite care services, agencies must meet the following requirements:

1. Licensed as a Home and Community Based Service (HCBS) Provider/In Home Respite Agency per Revised Statute 40:2120.1 et seq. and Louisiana Administrative Code (LAC) 48:I. Chapter 50 found at the following website: <http://www.doa.la.gov/Pages/osr/LAC-48.aspx>;
2. Completion of State-approved training according to a curriculum approved by OBH prior to providing the service, (See Appendix D);
3. Maintains documentation of verification of completion of required trainings for all staff; and
4. PT AE Respite Care Service Agency, PS 8E CSoc/Behavioral Health.

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Personal Care Attendant (PCA) Agency

To provide personal care attendant services, agencies must meet the following requirements:

1. Licensed as a HCBS provider/PCA agency per Revised Statute 40:2120.1 et seq. and LAC 48:I. Chapter 50 found at the following website: <http://www.doa.la.gov/Pages/osr/LAC-48.aspx>;
2. Completion of State-approved training according to a curriculum approved by OBH prior to providing the service, (See Appendix D);
3. Maintains documentation of verification of completion of required trainings for all staff; and
4. PT 82 Personal Care Attendant Agency, PS 8E CSoC/Behavioral Health.

Crisis Receiving Center

To provide crisis receiving center services, centers must meet the following requirements:

1. Licensed per Revised Statute 40:2180.11 et seq. and LAC 48: I. Chapters 53 and 54;
2. Completion of state approved training according to a curriculum approved by the OBH prior to providing the service, (See Appendix D);
3. Maintains documentation of verification of completion of required trainings for all staff; and
4. PT AF Crisis Receiving Center, PS 8E CSoC/Behavioral Health.

Child-Placing Agency (Therapeutic Foster Care)

To provide child-placing services, agencies must meet the following requirements:

1. Licensed as a Child-Placing Agency by the Department of Child and Family Services (DCFS) per Revised Statute 46:1401-1424;

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2. Completion of state approved training according to a curriculum approved by OBH prior to providing the service. (See Appendix D); and
3. Maintains documentation of verification of completion of required trainings for all staff.

Supervised Independent Living (SIL) Agency

To provide respite care services, agencies must meet the following requirements:

1. Licensed as a HCBS provider/PCA agency per Revised Statute 40:2120.1 et seq. and LAC 48:I. Chapter 50 found at the following website: <http://www.doa.la.gov/Pages/osr/LAC-48.aspx>;
2. Completion of state approved training according to a curriculum approved by OBH prior to providing the service. (See Appendix D);
3. Maintains documentation of verification of completion of required trainings for all staff; and
4. PT 89 Supervised Independent Living, PS 8E CSoC/Behavioral Health.

Limitations and Exclusions

1. Short-Term Respite will not duplicate any other Medicaid State Plan service or other services otherwise available to the member beneficiary at no cost (e.g., provided as charity care);
2. Short-term respite must address the needs identified in the assessment and address goals/objectives identified in the member’s individualized POC;
3. Local Education Agencies (LEAs) may not provide this service;
4. Short-term respite care pre-approved for the duration of 72 hours per episode, with a maximum of 300 hours allowed per calendar year. These limitations can be exceeded through prior authorization by the CSoC contractor or inclusion in the approved POC;

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5. Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the youth’s treatment record;
6. Medicaid federal financial participation (FFP) will not be claimed for the cost of room and board. The Medicaid rate does not include costs for room and board;
7. Respite care may be provided by a licensed respite care facility, with the availability of community outings. Community outings would be included on the approved POC and would include activities, such as school attendance, other school activities, or other activities the individual would receive if they were not receiving respite from a center-based respite facility. Such community outings would allow the individual’s routine not to be interrupted. Respite is not provided inside a provider facility;
8. Respite services provided by or in an Institution for Mental Disease (IMD) are not covered;
9. Short-term respite care may not be provided simultaneously with crisis stabilization services; and
10. Short-Term Respite may be provided concurrently with the development of the POC.

Allowed Mode(s) of Delivery

1. Individual; and
2. Off-site.

Additional Service Criteria

Services provided to children and youth must include communication and coordination with the family and/or legal guardian, including any agency legally responsible for the care or custody of the child. Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the youth’s treatment record. Time spent in coordination activities is not billable time. However, there is a factor for coordination built into the rates.

RECORD KEEPING

Components of Record Keeping

All provider records must be maintained in an accessible, standardized order and format at the office site in the Louisiana Department of Health (LDH)'s administrative region where the member resides. The provider must have sufficient space, facilities, and supplies to ensure effective record keeping. In addition, the provider must keep sufficient records to document compliance with LDH requirements for the member served and the provision of services.

A separate record must be maintained on each member that supports medical necessity for each billed service and fully documents service(s) for which payment(s) have been made. Documentation must be sufficient to enable LDH, or its designee, to verify that prior to payment each charge is due and proper. All records must be made available that LDH or its designee finds necessary to determine compliance with all federal or state laws, rules, or regulations promulgated by LDH.

Retention of Records

Administrative, personnel and member records must be maintained for whichever of the following time frames is longer:

1. Records are reviewed and all review questions are answered; or
2. Six (6) years from the date of the last payment period.

NOTE: Upon provider closure, all records must be maintained according to applicable laws, regulations and the above record retention requirements, and copies of the required documents transferred to the new agency.

Confidentiality and Protection of Records

All records, including administrative and member records, must be the property of the provider and secured against loss, tampering, destruction or unauthorized use. Employees of the provider must not disclose or knowingly permit the disclosure of any information concerning the provider, members or their families, directly or indirectly, to any unauthorized person. The provider must

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safeguard the confidentiality of any information that might identify the members or their families. Information may be released only under the following conditions:

1. Court order;
2. Member's written informed consent for release of information;
3. Written consent of the individual's legal guardian or legal representative when the member has been declared legally incompetent; or
4. Compliance with the Federal Confidentiality Law of Alcohol and Drug Abuse Patients Records (42 CFR, Part 2).

Upon request, a provider must make available information in the case records to the member or legally responsible representative. If, in the professional judgment of the administration of the agency, it is felt that information contained in the record would be damaging to the member, that information may be withheld from the member, except under court order.

The provider may charge a reasonable fee for providing the above records. This fee cannot exceed the community's competitive copying rate.

Material from case records may be used for teaching or research purposes, development of the governing body's understanding and knowledge of the provider's services, or similar educational purposes, if names are deleted and other similar identifying information is disguised or deleted. Any electronic communication containing member specific identifying information sent by the provider to another agency, or to LDH, must comply with regulations of the Health Insurance Portability and Accountability Act (HIPAA) and be sent securely via an encrypted messaging system. A system must be maintained that provides for the control and location of all member records.

NOTE: Under no circumstances shall providers allow staff to take member's case records from the office without appropriate utilization of standard best practices in compliance with all HIPAA standards related to privacy and security.

Review by State and Federal Agencies

All administrative, personnel and member records must be made available to LDH, or its designee, and appropriate state and federal personnel at all times. Providers must always safeguard the confidentiality of member information.

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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:

1. Member Rights - reviewed, signed by, and given to the member and/or responsible party, if applicable:
 - a. Psychiatric advanced directive and Medical advanced directive;
 - b. Consent for treatment/Informed consent; and
 - c. Informed consent to deliver telemedicine/telehealth services. The consent form must include the following:
 - i. Rationale for using telemedicine/telehealth in place of in-person services;
 - ii. Risks and benefits of the telemedicine/telehealth, including privacy-related risks;
 - iii. Possible treatment alternatives and those risks and benefits; and
 - iv. Risks and benefits of no treatment.
 - d. Rights to confidentiality must be reviewed, signed by, and given to the member and/or responsible party, if applicable.
2. Name and date of birth of the member;

Note: Each page of the record shall have a member identifier such as member name, member initials, member's client ID number, etc.
3. Social security number of the member;

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4. Address of the individual;
5. Dates and time of service;
6. Assessments;
7. Treatment plans, based on and consistent with the assessment, which include at a minimum:
 - a. Indication if treatment plan is an initial or an updated treatment plan;
 - b. Goals and objectives, which are specific, measureable, action oriented, realistic and time-limited;
 - c. Specific interventions;
 - d. Service locations for each intervention;
 - e. Staff providing the intervention;
 - f. Estimated frequency and duration of service; and
 - g. Signatures of the licensed mental health professional (LMHP), member, and responsible party, i.e., guardian/caregiver, if applicable;
 - h. Updated when there are significant life changes, achieved goals, or new problems identified; and
 - i. Progression made towards all goals.
8. Progress notes;
9. Units of services provided;
10. Crisis plan;
 - a. Crisis plan must be directed by the member and/or the responsible party, i.e., guardian/caregiver, if applicable; and

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- b. Crisis plan must include signatures of the member and/or the responsible party, i.e., guardian/caregiver, if applicable.
11. Continuity and coordination of care:
- a. The record includes the primary care physician (PCP) name, address, phone number, and documentation of continuity and coordination of care between PCP and the member’s treating provider;
 - b. The record includes any other treating behavioral health clinician’s name, address, phone number, and documentation of continuity and coordination of care between any other treating behavioral health clinician’s and the member’s treating provider;
 - c. The record includes documentation of any referrals made on behalf of the member, if applicable; and
 - d. The record must include a signed Release of Information form by the member and/or responsible party, i.e., guardian/caregiver, if applicable, for communication and coordination of care to occur; if member and/or responsible party refuses, then this refusal must be noted within the record.
12. Medication management, if applicable:
- a. The record must indicate the following:
 - i. Medication name;
 - ii. Medication type;
 - iii. Medication frequency of administration;
 - iv. Medication dosage;
 - v. Person who administered each medication;
 - vi. Medication route;
 - vii. Ordered lab work that has been reviewed by the clinician ordering the lab work as evidenced by date and signature of clinician;

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- viii. Evidence of member education on prescribed medication including benefits, risks, side effects, and alternatives of each medication;
 - ix. Signed consent for psychotropic medications by the member and/or responsible party, i.e., guardian/caregiver, if applicable; if member and/or responsible party refuses, then this refusal must be noted within the record;
 - x. AIMS (Abnormal Involuntary Movement Scale) preformed when appropriate (e.g., member is being treated with antipsychotic medication);
 - xi. Initial and ongoing medical screenings are completed for members prescribed antipsychotic medication including but not limited to weight, BMI, labs, and chronic conditions to document ongoing monitoring; and
 - xii. Documentation of monitoring medication adherence, efficacy, and adverse effects.
13. Discharge plan;
- a. Appointment date and/or time period of follow up with transitioning behavioral health provider and/or primary care physician, if medical comorbidity is present, must be documented on the discharge plan. Provider must document any barriers if unable to schedule an appointment when member is discharged or transitioned to a different level of care;
 - b. Provider must ensure collaborative transition of care occurred with the receiving clinician/program as evidenced by documented communication. Provider must document any barriers if unable to communicate with the receiving clinician/program when member is discharged or transitioned to a different level of care; and
 - c. Medication profile, if applicable, provided to outpatient provider and to member during transition of care. Provider must document any barriers while reviewing the transition of care with member or while providing the medication profile to the outpatient provider.

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

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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. Electronic signature is attributable to signer (i.e. be sure to have patient’s printed name under signature); and
3. Appropriate security measures are 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:

1. Name of the person making the entry;
2. Signature of the person making the entry;
3. Functional title, applicable educational degree and/or professional license of the person making the entry;
4. Full date of documentation; and
5. 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.

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

1. Name of member;
2. Name of provider and employee providing the service(s);
3. Service provider contact telephone number;
4. Date of service contact;
5. Start and stop time of service contact; and
6. 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.

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 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. 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.

Progress Summaries

A progress summary is a synthesis of all activities and services for a specified period (at least every 90 days or more often if required by the managed care organization (MCO) or Coordinated System

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of Care (CSOC) contractor) which addresses each member's assessed needs, progress toward the member's desired personal outcomes, and changes in the member's progress and service needs. This summary must be of sufficient detail and analysis to allow for evaluation of the appropriateness of the member's treatment plan, sufficient information for use by supervisors, and evaluation of activities by program monitors.

Progress summaries must:

1. Document the time period summarized;
2. Indicate who was contacted, where contact occurred and what activity occurred;
3. Record activities and actions taken, by whom, and progress made;
4. Indicate how the member is progressing toward the personal outcomes in the treatment plan, as applicable;
5. Document delivery of each service identified on the treatment plan, as applicable;
6. Document any deviation from the treatment plan;
7. Record any changes in the member's medical condition, behavior or home situation that may indicate a need for a reassessment and treatment plan change, as applicable;
8. Be legible (including signature) and include the functional title of the person making the entry and date;
9. Be complete and updated in the record in the time specified;
10. Be complete and updated by the supervisor (if applicable) in the record as progress summary at the time specified;
11. Be recorded more frequently when there is frequent activity or when significant changes occur in the member's service needs and progress;
12. Be signed by the person providing the services; and
13. Be entered in the member's record when a case is transferred or closed.

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Progress summaries must be documented in a narrative format that reflects delivery of each service and elaborates on the activity of the contact. Progress summaries must be of sufficient content to reflect descriptions of activities and cannot be so general that a complete picture of the services and progress cannot be easily determined from the content of the note.

NOTE: General terms and phrases such as “called the member”, “supported member”, or “assisted member” are not sufficient and do not reflect adequate content. Checklists alone are not adequate documentation.

Discharge Summary for Transfers and Closures

A discharge summary details the member’s progress prior to a transfer or closure. A discharge summary must be completed within 14 calendar days following a member’s discharge.

Forms and Links

Standardized Basic Clinical Competency Training Modules for Unlicensed Staff

Link to training modules on the Louisiana Department of Health (LDH) website:
<http://new.LDH.louisiana.gov/index.cfm/page/2473>.

Approved Independent Living/ Skills Building (II/Sb) Curriculum - Youth

Casey Life Skills – <https://www.casey.org/casey-life-skills/>

Behavioral Health Service (BHS) Provider License

Information and regulations associated with the BHS license rule may be found on the Louisiana Health Standards Section website available at the following link:
<http://dhh.louisiana.gov/index.cfm/directory/detail/7950/catid/154>.

Information and regulations associated with other licenses issued by the Louisiana Health Standards Section may be found under the Programs section on their website at the following link:
<http://dhh.louisiana.gov/index.cfm/subhome/32>.

CMS Emergency Preparedness Regulation Guidance and Resources

<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html>

First Aid, Cardiopulmonary Resuscitation (CPR) and Seizure Assessment Training

Agencies, organizations and facilities are required to ensure staff complete an American Heart Association (AHA) recognized first aid, CPR and seizure assessment training. Staff must renew certifications at least once every two years or as recommended by the AHA. Psychiatrists, APRNs/CNSs/PAs, RNs and LPNs are exempt from this training. Courses may be found by visiting the AHA website: <http://www.heart.org/HEARTORG/>

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Please see the FFT website for additional information: www.fftinc.com

Substance Abuse and Mental Health Service Administration's (SAMHSA) online guide for establishing drug-free workplace programs and developing written policies. This resource may be found at the following link: <http://www.samhsa.gov/workplace/toolkit/develop-policy>.

General Information and Administration Provider Manual

Providers should refer to Chapter 1 - General Information and Administration of the *Medicaid Services Manual* for additional information on provider enrollment and requirements, including general standards for participation. This manual chapter may be found at the following link: <http://www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf>.

National Wraparound Initiative (NWI) Resources

Please see the NWI website for additional information: <https://nwi.pdx.edu/>

Ten Principles of the Wraparound Process: [https://nwi.pdx.edu/NWI-book/Chapters/Bruns-2.1-\(10-principles-of-wrap\).pdf](https://nwi.pdx.edu/NWI-book/Chapters/Bruns-2.1-(10-principles-of-wrap).pdf)

Phases and Activities of the Wraparound Process: Building Agreement about a Practice Model: [https://nwi.pdx.edu/NWI-book/Chapters/Walker-4a.1-\(phases-and-activities\).pdf](https://nwi.pdx.edu/NWI-book/Chapters/Walker-4a.1-(phases-and-activities).pdf)

Praed Foundation

Please see the Praed Foundation website for Child and Adolescent Needs and Strengths (CANS) training and recertification: www.canstraining.com

Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE)

OIG's LEIE provides information regarding individuals and entities excluded from participation in Medicare, Medicaid and all other Federal health care programs. The OIG LEIE exclusion database is found at the following link: <https://exclusions.oig.hhs.gov/>.

LDH Adverse Actions List Search

The LDH Adverse Actions List Search is a database containing all individuals and providers who are sanctioned, which may include exclusions, for-cause terminations, or disbarment through LDH Health Standards. The LDH Adverse Actions List Search can be found on the following link: <https://adverseactions.ldh.la.gov/SelSearch>.

GLOSSARY

The following is a list of abbreviations, acronyms and definitions used in the Behavioral Health Services manual chapter.

Ambulatory Withdrawal Management with Extended On-Site Monitoring (ASAM Level 2 WM) - An organized outpatient addiction treatment service that may be delivered in an office setting or health care or behavioral health services provider by trained clinicians who provide medically supervised evaluation, detoxification and referral services. The services are designed to treat the client’s level of clinical severity to achieve safe and comfortable withdrawal from mood-altering chemicals and to effectively facilitate the client’s entry into ongoing treatment and recovery. The services are provided in conjunction with intensive outpatient treatment services (level II.1).

ASAM - American Society of Addiction Medicine

Assertive Community Treatment (ACT) - Services provided as interventions that address the functional problems of individuals who have the most complex and/or pervasive conditions associated with a major mental illness or co-occurring addictions disorder. These interventions are strength-based and focused on promoting symptom stability, increasing the individual’s ability to cope and relate to others and enhancing the highest level of functioning in the community.

Child Specialist (Addiction Services) - An individual, who has documentation verifying the required minimum of 90 clock hours of education and training in child development and/or early childhood education.

Clinically Managed High-Intensity Residential Treatment (ASAM Level 3.5) - A residential program that offers continuous observation, monitoring, and treatment by clinical staff designed to treat clients experiencing substance-related disorders who have clinically-relevant social and psychological problems, such as criminal activity, impaired functioning and disaffiliation from mainstream values, with the goal of promoting abstinence from substance use and antisocial behavior and affecting a global change in clients’ lifestyles, attitudes and values.

Clinically Managed Low Intensity Residential Treatment (ASAM Level 3.1) – A residential program that offers at least five hours a week of a combination of low intensity clinical and recovery-focused services for substance-related disorders. Services may include individual, group and family therapy, medication management and medication education, and treatment is directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility and reintegrating the client into the worlds of work, education and family life (e.g., halfway house).

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Clinically Managed Medium-Intensity Residential Treatment (ASAM Level 3.3 - A residential program that offers at least 20 hours per week of a combination of medium-intensity clinical and recovery focused services in a structured recovery environment to support recovery from substance-related disorders; is frequently referred to as extended or long term care.

Clinically Managed Residential Social Withdrawal Management (ASAM LEVEL 3.2 WM) - An organized residential program utilizing 24 hour active programming and containment provided in a non-medical setting that provides relatively extended, sub-acute treatments, medication monitoring observation, and support in a supervised environment for a client experiencing non-life threatening withdrawal symptoms from the effects of alcohol/drugs and impaired functioning and who is able to participate in daily residential activities.

Community Psychiatric Support and Treatment (CPST) - A comprehensive service which focuses on reducing the disability resulting from mental illness, restoring functional skills of daily living, building natural supports and solution-oriented interventions intended to achieve identified goals or objectives as set forth in the individualized treatment plan.

Coordinated System of Care (CSoC) - An innovative reflection of two powerful movements in health care: coordination of care for individuals with complex needs and family-driven and youth-guided care. CSoC is guided by an overarching System of Care (SOC) philosophy and values, which include: family driven, youth guided, home and community based, strengths base, individualized, culturally and linguistically competent, integration across systems, connection to natural supports, data driven and outcomes oriented and unconditional care.

Crisis Intervention (CI) - Services provided to a person who is experiencing a psychiatric crisis and are designed to interrupt and/or ameliorate a crisis experience, through a preliminary assessment, immediate crisis resolution and de-escalation and referral and linkage to appropriate community services to avoid more restrictive levels of treatment.

Crisis Stabilization (CS) - Services intended to provide short-term and intensive supportive resources for the youth and their family. The intent of this service is to provide an out-of-home crisis stabilization option for the family in order to avoid psychiatric inpatient and institutional treatment of the youth by responding to potential crisis situations.

EP - A service provided as part of Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.

FDA - Food and Drug Administration (FDA) is an agency within the U.S. Department of Health and Human Services. The FDA's organization consists of the Office of the Commissioner and four directorates overseeing the core functions of the agency: Medical Products and Tobacco, Foods, Global Regulatory Operations and Policy, and Operations.

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Federally Qualified Health Center (FQHC) - An entity authorized under §330 of the Public Health Service (PHS) Act to receive grant funding to provide health care services and improve the health status of medically underserved populations. The U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) certifies FQHC status.

Functional Family Therapy (FFT) and Functional Family Therapy-Child Welfare (FFT-CW) - FFT and FFT-CW are deemed a best practice/family-based approach to providing treatment to youth who are between the ages of 10 and 18 (0 to 18 for FFT-CW) and are exhibiting significant externalizing behaviors. It is a systems-based model of intervention/prevention, which incorporates various levels of the member's interpersonal experiences to include cognitive, emotional and behavioral experiences, as well as intrapersonal perspectives which focus on the family and other systems (within the environment) and impact the youth and their family system. FFT and FFT-CW are strengths-based models of intervention, which emphasize the capitalization of the resources of the youth, their family and those of the multi-system involved. Its purpose is to foster resilience and ultimately decrease incidents of disruptive behavior for the youth. More specifically, some of the goals of the service are to reduce intense/ negative behavioral patterns, improve family communication, parenting practices and problem-solving skill, and increase the family's ability to access community resources.

Homebuilders® - An intensive, in-home Evidence-Based Program (EBP) utilizing research based strategies (e.g. Motivational Interviewing, Cognitive and Behavioral Interventions, Relapse Prevention, Skills Training), for families with children (birth to 18 years) at imminent risk of out of home placement (requires a person with placement authority to state that the child is at risk for out of home placement without Homebuilders), or being reunified from placement.

House Manager (Addiction Services) - A person who supervises activities of the facility when the professional staff is on call, but not on duty. This person is required to have adequate orientation and skills to assess situations related to relapse and to provide access to appropriate medical care when needed.

Human Services Field - Academic program with a curriculum content in which at least 70 percent of the required courses are in the study of behavioral health or human behavior.

Independent living/skills building services - Services designed to assist children who, are or will be, transitioning to adulthood beginning at the age of 14 years old with support in acquiring, retaining and improving self-help, socialization and adaptive skills necessary to be successful in the domains of employment, housing, education and community life and to reside successfully in home and community settings.

Intensive Outpatient Treatment (ASAM Level 2.1) - Professionally directed assessment, diagnosis, treatment and recovery services provided in an organized non-residential treatment setting, including individual, group, family counseling and psycho-education on recovery as well as monitoring of drug use, medication management, medical and psychiatric examinations, crisis

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mitigation coverage and orientation to community-based support groups. Services may be offered during the day, before or after work or school, in the evening or on a weekend, and the program must provide nine or more hours of structured programming per week for adults and six or more hours of structured programming per week for children/adolescents.

Licensed Mental Health Professional (LMHP) - An individual who is licensed in the State of Louisiana to diagnose and treat mental illness or substance use, acting within the scope of all applicable State laws and their professional license. An LMHP includes the following individuals who are licensed to practice independently: Medical psychologists, licensed psychologists, licensed clinical social workers (LCSWs), licensed professional counselors (LPCs), licensed marriage and family therapists (LMFTs), licensed addiction counselors (LACs), and advanced practice registered nurses (APRNs). See Appendix D for further details.

Medically Monitored Intensive Residential Treatment (ASAM Level 3.7) - Residential program that provides a planned regimen of 24-hour professionally directed evaluation, observation, medical monitoring and addiction treatment to clients with co-occurring psychiatric and substance disorders whose disorders are so severe that they require a residential level of care but do not need the full resources of an acute care hospital. The program provides 24 hours of structured treatment activities per week, including, but not limited to, psychiatric and substance use assessments, diagnosis treatment, and habilitative and rehabilitation services.

Medically Monitored Residential Withdrawal Management (ASAM Level 3.7 WM) - A residential program that provides 24-hour observation, monitoring and treatment delivered by medical and nursing professionals to clients whose withdrawal signs and symptoms are moderate to severe and thus require residential care, but do not need the full resources of an acute care hospital.

Medically Necessary Services - Health care services that are in accordance with generally accepted evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. With regards to behavioral health services, the medical necessity for services shall be determined by an LMHP or physician who is acting within the scope of their professional license and applicable state law.

Medically Stable – The member appears to be in no acute medical or physical distress, and reports no acute or chronic health symptoms or problems for which medical treatment beyond routine medical care is required or anticipated. Those with a chronic, but stable illness, managed with medication and routine monitoring, such as diabetes, hypertension, or a well-controlled seizure disorder, may be considered medically stable.

Multi-Systemic Therapy (MST) - Services that provide an intensive home/family and community-based treatment for youth who are at risk of out-of-home placement or who are returning from out-of-home placement.

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Outpatient Therapy by Licensed Practitioners - Other Licensed Practitioner Outpatient Therapy - Individual, family, and group outpatient psychotherapy, mental health assessment, evaluation, testing, medication management, psychiatric evaluation, medication administration, individual therapy with medical evaluation and management and case consultation.

Parent Support and Training (PST) - Training designed to benefit the parent/primary caregiver of Medicaid-eligible child/youth experiencing a severe emotional disorder (SED) who is eligible for the CSoC and is at risk of out-of-home placement. This service provides the training and support necessary to ensure engagement and active participation of the family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process.

Psychosocial Rehabilitation (PSR) - Services designed to assist the individual with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their mental illness.

Rural Health Clinic (RHC) - An entity authorized under the Rural Health Clinic (RHC) Act of 1977 to encourage and stabilize the provision of outpatient primary care in rural areas through cost-based reimbursement. These entities may be independent (a free-standing practice that is not part of a hospital, skilled nursing facility or home health agency) or provider-based (an integral and subordinate part of a hospital, skilled nursing facility or home health agency).

Short term respite care - Temporary direct care and supervision for the child/youth in the child's home or a community setting that is not facility-based (i.e., not provided overnight in a provider-based facility).

Unlicensed professionals (UPs) - Unlicensed professionals of addiction services must be registered with the Addictive Disorders Regulatory Authority (ADRA) and demonstrate competency as defined by the Louisiana Department of Health (referenced above), state law (RS 37:3386 et seq.) and regulations. Unlicensed addiction provider must meet at least one of the following qualifications: 1) Master's-prepared behavioral health professional that has not obtained full licensure privileges and is participating in ongoing professional supervision. When working in addiction treatment settings, the master's prepared UP shall be supervised by an LMHP, who meets the requirements of this Section; 2) be a registered addiction counselor; 3) be a certified addiction counselor; 4) be a counselor in training (CIT) that is registered with ADRA and is currently participating in a supervisory relationship with an ADRA-registered certified clinical supervisor.

Youth Support and Training (YST) services – Delivered by a trained youth peer, child/youth-centered services that provide the training and support necessary to ensure engagement and active participation of the youth in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process.

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APPENDIX C: MEDICAL NECESSITY AND EPSDT EXCEPTIONS

POLICY

MEDICAL NECESSITY AND EPSDT EXCEPTIONS POLICY

Medical Necessity

Medically necessary services are defined as those health care services that are in accordance with generally accepted evidence-based medical standards, or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care (LAC Title 50, Part I, Chapter 11).

In order to be considered medically necessary, services must be:

1. Deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and
2. Those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the member.

Any such services must be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more, nor less, than what the member requires at that specific point in time.

Although a service may be deemed medically necessary, it doesn't mean the service will be covered under the Medicaid program. Services that are experimental, non-FDA approved, investigational or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary".

The Medicaid director, in consultation with the Medicaid medical director, may consider authorizing services at their discretion on a case-by-case basis.

Procedures for Coverage of a Non-Covered Service Identified as Medically Necessary for EPSDT Members

For a service that is not covered under the Medicaid State Plan, but deemed medically necessary for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program members, information is submitted to the medical director for review. Information should include the following:

1. Information regarding the member, including age, diagnosis, condition and medical records relative to the service being requested;

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APPENDIX C: MEDICAL NECESSITY AND EPSDT EXCEPTIONS

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2. Information regarding the provider, enrollment status and qualifications for rendering service, as appropriate; and
3. Information regarding the requested service is gathered. This information would include, but not be limited to, reasons/policy for non-coverage, applicable rules and State Plan amendment (SPA), alternative services, etc. All supporting information for coverage and medical necessity in individual cases is gathered.

The Medicaid medical director reviews as much information on the member as possible, the prospective provider and the requested service, to determine if the service being requested is medically necessary, and if other possible treatment options exist and/or if there are rules, SPAs or federal regulations impacting coverage decision.

If approved for medical necessity, then a determination of availability of federal financial participation (FFP) is made. If FFP is not available due to federal regulations, a recommendation for coverage, and a request to pay out of all State funds, is forwarded for approval to the Medicaid director. If the service is determined medically necessary, but is investigational or experimental, the recommendation is sent to the medical director for consideration of final approval and appropriate match rate.

The payment of authorized services that are normally not a Medicaid-covered benefit are specially handled through the system to ensure payment for the specified member occurs and no other non-intended members' services are paid. The CSoC Contractor will submit an invoice, including the approved EPSDT exceptions and supporting encounter data for the claims for the EPSDT with an EP modifier. The Medicaid Management Information Systems (MMIS) will accept all encounters with an EP modifier but will create a report for the State to do 100 percent verification reviews for audit purposes. Reimbursement for any inappropriately approved EPSDT exceptions will be recouped from the CSoC Contractor and provider by the State.

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Approved Curriculum and Equivalency Standards

Parent Support and Training/Youth Support and Training

Equivalency Standards

Introduction to Wraparound

This initial training introduces new parent support and training and youth support and training staff to systems of care and system of care values.

Participants learn the definition, phases and principles, and goals of wraparound from the National Wraparound Institute perspective. Participants have an opportunity to practice the following skills that support:

1. Describing wraparound;
2. Determining Family Support Organization (FSO) staff goals during the various phases of wraparound;
3. Putting wraparound principles into practice; and
4. Meaningfully participating in the wraparound process as partners with professionals and others.

Functional Behavioral Approach

This intensive training introduces new parent support and training, and youth support and training staff to family support, which is, essentially, systems of care values in practice. Participants engage in interactive exercises and activities to learn and practice the key competencies of providing support, teaching skills, and building and maintaining community connection for the youth and families they serve. They are exposed to tools and strategies to support each of the competencies, that also help provide ongoing assessment of whether their service is “on track” to best support child family team (CFT)-defined needs.

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Supervising Functional Behavioral Approach

This training for those supervising parent supports and youth supports, allows supervisors to bring their experiences into a session where the original and more advanced tools and strategies are introduced and applied, to demonstrate how they can take these back to their staff and deepen service results for those they are serving.

Approved Curriculum

1. Introduction to Wraparound;
2. Functional behavioral approach (FBA);
3. Supervising FBA (for parent support supervisors and youth support supervisors);
and
4. Each FSO is required to have and utilize a comprehensive peer training plan and curriculum, which 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)-Coordinated System of Care (CSoc).

Independent Living/Skill Building

Equivalency Standards

Training will address the principles of the system of care in that services are to be individualized according to each youth’s strengths, interests, skills, goals and included on an individualized plan of care.

Training may include facilitating normal and instrumental activities of daily living. Participants will learn how to assess needs of the youth and teach skills needed by youth for living independently, which include the following domains:

1. Career planning;
2. Communication;

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3. Daily living;
4. Home life;
5. Housing and money management;
6. Self-care;
7. Social relationships;
8. Work life; and
9. Work and study skills.

Approved Curriculum

Casey Life Skills is the approved curriculum for independent living/skill building (IL/SB) services. (See Appendix A of this manual chapter for access to link).

Short Term Respite Care

Equivalency Standards

Respite providers will need to learn how to help to de-escalate stressful situations and assure that the respite experience provides a therapeutic outlet for the child.

Training will focus on:

1. Developing successful partnerships with families and youth; and
2. Understanding culture and values.

Knowledge of:

1. System of care values of family driven care;
2. Individualized treatment, and strengths based approaches;

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3. Safety (cardiopulmonary resuscitation (CPR)), first aid, environmental awareness, community safety, etc.);
4. Basic communication skills;
5. Behavioral strategies for managing challenging behaviors, use of positive behavioral supports; and
6. Non-violent prevention of aggressive behavior.

Approved Curriculum

The Family Involvement Center’s Short Term Respite Provider Training is the Office of Behavioral Health (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:

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

OBH approved short term respite training can be requested from Magellan of Louisiana at: LACSOCPROVIDERQUESTIONS@magellanhealth.com.

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Peer Support Specialists and Family Peer Support Specialists

Approved Curriculum

The recognized peer support specialist (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 SAMHSA, and has been approved by 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 recognized family peer support specialist (RFPSS) employed by the provider agency must successfully complete a comprehensive peer training plan and curriculum that is inclusive of the core competencies for family peer specialists, as outlined by the National Federation of Families for Children’s Mental Health (NFFCMH), and has been approved by OBH. Training must provide the RFPSS 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 RPSS or RFPSS must complete a minimum of ten (10) continuing education units (CEU) in the tenets of peer (for the RPSS), or family peer (for the RFPSS), 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, or family 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/family peer support must 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 RPSS or RFPSS will be considered to be lapsed. CEU courses may include:

1. Wellness and Recovery;
2. Cultural Competency;
3. Person Centered Care;

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4. Mutuality;
5. Advocacy;
6. Communication;
7. Conflict Resolution;
8. Trauma Informed Care;
9. Integrated Care;
10. Partnering with Other Professionals;
11. Wellness Recovery Action Plan (WRAP);
12. Peer Support Whole Health;
13. Intentional Peer Support;
14. Mental Health First Aid;
15. Suicide Prevention;
16. Treatment/Discharge Planning;
17. Health Insurance Portability and Accountability Act (HIPAA);
18. Mandated Reporting;
19. Target Health; and
20. Chronic Conditions.

Psychosocial Rehabilitation

Equivalency Standards

Services are designed to assist the individual with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their mental illness. The intent of psychosocial rehabilitation (PSR) is to restore the fullest possible integration of the

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individual as an active and productive member of their family, community and/or culture with the least amount of ongoing professional intervention.

Training will focus on:

1. Daily and community living skills;
2. Socialization skills;
3. Adaptation skills;
4. Development of leisure time interests and skills;
5. Symptom management skills;
6. Identification and management of symptoms of mental illness;
7. Compliance with physician's medication orders;
8. Education in mental health/mental illness; and
9. Work readiness activities

Crisis Response Services (MCR, BHCC, CBCS) for Adults (Effective 3/1/2022_for MCR and CBCS and 4/1/22 for BHCC) and Crisis Response Services (MCR, CBCS) for Youth (Effective 4/01/2024)

Approved Curriculum

The LSU Center for Evidence to Practice is the OBH-approved trainer for crisis providers. All required initial trainings and ongoing training and consultation 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:

1. Topics of training may include, but are not limited to, the following:
 - a. Overview of Louisiana's Crisis System Continuum;

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- b. Crisis 101;
- c. Person-Centered, Collaborative Engagements, Shared Decision Making & Voluntary Approach;
- d. Stabilization, Regaining Cognitive Functioning and Resolution-Focused;
- e. Trauma, Suicide, Mental Illness, Intellectual Disabilities and Substance Use Related to Crisis;
- f. Verbal De-Escalation, Basics of Motivation, Empathic Response;
- g. Assessment of Risk, Lethality Assessment/Scales;
- h. Safety – Yours and Theirs (Safety Planning);
- i. Peer Support in Crisis Response;
- j. Self-Management Tools for Clients/Community/Consumers;
- k. Voices of Those with Lived Experiences (Focus on Crisis);
- l. 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;
- m. Self-Care, Self-Care Plans, and Sharing for Crisis Responders;
- n. Supervision (Who, What, When; Decision Making; Mandatory/Discretionary);
- o. Billing and Documentation of Services; and
- p. Continuous Quality Improvement Measures and Reporting.

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

Crisis Stabilization

Equivalency Standards

The goal of crisis stabilization (CS) services is to restore the member to their prior functioning level following a crisis. Bolstering coping skills and assisting in revitalizing or developing a support system are essential portions of stabilization services. The member may need a person who is capable of providing verbal support or their physical presence to make the member feel safe.

Curriculum standards for crisis stabilization services include but would not be limited to:

1. Solution focused crisis assessments;
2. Crisis communications;
3. Intensive, solution focused interventions;
4. Assisting the youth and family members in developing coping and behavior management skills, and working collaboratively with any existing service providers to prepare for the youth’s return to their home environment; and
5. Development of risk management / safety plans.

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Standardized Basic Clinical Competency Training Modules for Unlicensed Staff

OBH developed standardized basic training modules for unlicensed providers and direct care staff as an introduction to the key concepts and competencies they must demonstrate prior to rendering specialized behavioral health services to members of Healthy Louisiana and CSoC.

These modules are available online through the Healthy Louisiana managed care organizations (MCOs), the CSoC contractor, and LDH. Staff must complete these trainings prior to rendering specialized behavioral health services, and provider agencies are required to submit attestation documentation to the managed care entities with whom they contract.

Training focuses on:

1. MH 101 – Introduction to Serious Mental Illness (SMI) and Emotional Behavioral Disorders;
2. Crisis intervention;
3. Suicide and homicide precautions;
4. System of care overview;
5. Co-occurring disorders;
6. Cultural and linguistic competency (basic); and
7. Treatment planning.

Licensed Mental Health Professional

An LMHP is an individual who is licensed in the state of Louisiana to diagnose and treat mental illness or substance use, acting within the scope of all applicable State laws and their professional license. An LMHP includes individuals licensed to practice independently:

1. Medical psychologists;
2. Licensed psychologists;

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3. Licensed clinical social workers (LCSWs);
4. Licensed professional counselors (LPCs);
5. Licensed marriage and family therapists (LMFTs);
6. Licensed addiction counselors (LACs); and
7. Advanced practice registered nurses (APRNs).

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, which is consistent with their professional training as prescribed by R.S. 37:1101 et seq. However, LPCs may not assess, diagnose, or provide treatment to any individual suffering from a 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. (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 their professional training as prescribed by R.S. 37:1101 et seq. However, LMFTs may not assess, diagnose, or provide treatment to any individual suffering from a 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). 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.

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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.

Resources:

1. First Aid, Cardiopulmonary Resuscitation and Seizure Assessment Training

Agencies, organizations and facilities are required to ensure staff complete an American Heart Association (AHA) recognized first aid, CPR and seizure assessment training. Staff must renew certifications at least once every two years or as recommended by the AHA. Psychiatrists, APRNs/clinical nurse specialists (CNSs)/physician assistants (PAs), registered nurses (RNs), and licensed practical nurses (LPNs) are exempt from this training. Courses may be found by visiting the AHA website: <http://www.heart.org/HEARTORG/>.

2. Establishing Drug-Free Workplace Programs and Developing Policies

Agencies, organizations and facilities may refer to the SAMHSA online guide for establishing drug-free workplace programs and developing written policies. This resource may be found at the following link: <http://www.samhsa.gov/workplace/toolkit/develop-policy>.

3. 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>.

Information and regulations associated with other licenses issued by the LDH Health Standards Section may be found under the Programs section on their website at the following link: <http://dhh.louisiana.gov/index.cfm/subhome/32>.

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APPENDIX E-1: EVIDENCE BASED PRACTICES (EBPs)

ASSERTIVE COMMUNITY TREATMENT

Assertive Community Treatment

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 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, daily activities, health and safety, medication support, harm reduction, money management, entitlements, service planning, and coordination.

Employment services provided through ACT programming adhere to tenets of the Individual Placement and Support (IPS) model of supported employment. IPS is an evidence-based practice of supported employment for members with mental illness designed to enhance the quality of employment services and overall employment outcomes for members.

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

1. 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;
2. To meet basic needs and enhance quality of life;
3. To improve functioning in adult social and employment roles and activities through the provision of evidence-based employment supports;
4. To increase community tenure; and
5. To lessen the family’s burden of providing care and support healthy family relationships.

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APPENDIX E-1: EVIDENCE BASED PRACTICES (EBPs)

ASSERTIVE COMMUNITY TREATMENT

Fundamental principles of this program are:

1. The ACT team is the primary provider of services and, as such, functions as the fixed point of responsibility for the member;
2. Services are provided in the community; and
3. The services are person-centered and individualized to each member.

Target population

ACT serves members eighteen (18) years of age 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.

The member must have one of the following diagnoses:

1. Schizophrenia;
2. Other psychotic disorder;
3. Bipolar disorder; and/or
4. Major depressive disorder.

These may also be accompanied by any of the following:

1. Substance use disorder; or
2. Developmental disability.

These may also include one or more of the following service needs:

1. Two (2) or more acute psychiatric hospitalizations and/or four (4) or more emergency room visits in the last six (6) months;
2. Persistent and severe symptoms of a psychiatric disability that interferes with the ability to function in daily life;

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3. Two (2) or more interactions with law enforcement in the past year for emergency services due to mental illness or substance use (this includes involuntary commitment);
4. Currently residing in an inpatient bed, but clinically assessed to be able to live in a more independent situation if intensive services were provided;
5. One or more incarcerations in the past year related to mental illness and/or substance use (Forensic Assertive Community Treatment (FACT));
6. Psychiatric and judicial determination that FACT services are necessary to facilitate release from a forensic hospitalization or pre-trial to a lesser restrictive setting (FACT); or
7. Recommendations by probation and parole, or a judge with a FACT screening interview, indicating services are necessary to prevent probation/parole violation (FACT).

Must have one (1) of the following:

1. Inability to participate or remain engaged in or respond to traditional community-based services;
2. Inability to meet basic survival needs, or residing in substandard housing, homeless or at imminent risk of becoming homeless; or
3. Services are necessary for diversion from forensic hospitalization, pretrial release, or as a condition of probation to a lesser restrictive setting (FACT).

Must have at least three (3) of the following:

1. Evidence of co-existing mental illness and substance use disorder;
2. Significant suicidal ideation, together with a plan and the ability to carry out such a plan, within the last two (2) years;
3. Suicide attempt in the prior two (2) years;

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4. History of violence due to untreated mental illness and/or substance use within the prior two (2) years;
5. Lack of support systems;
6. History of inadequate follow-through with treatment plan, resulting in psychiatric or medical instability;
7. Threats of harm to others in the prior two (2) years;
8. History of significant psychotic symptomatology, such as command hallucinations to harm others; or
9. Minimum LOCUS score of three (3) at admission.

Exception criteria:

1. The member does not meet the medical necessity criteria above, but is recommended as appropriate to receive ACT services by the 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:
 - a. Members discharging from institutions such as nursing facilities, prisons, and/or inpatient psychiatric hospitals;
 - b. Members with frequent incidence of emergency department (ED) presentations and/or involvement with crisis services; and
 - c. 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:
 - i. Medicaid-eligible members over age eighteen (18) with SMI currently residing in NF; or
 - ii. 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.

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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 the following:

1. Psychiatric history, status, and diagnosis;
2. Level of Care Utilization System (LOCUS);
3. Telesage Outcomes Measurement System, as appropriate;
4. Psychiatric evaluation;
5. Strengths assessment;
6. Housing and living situation;
7. Educational and social interests and capacities;
8. Self-care abilities;
9. Family and social relationships;
10. Family education and support needs;
11. Physical health;
12. Alcohol and drug use;
13. Legal situation; and
14. Personal and environmental resources.

Utilizing the comprehensive person centered needs assessment, an initial vocational assessment (referred to as the “career profile”) in addition to member interviews, shall be completed on all individuals participating in the ACT program within thirty (30) calendar days after program entry for members admitted on or after 10/01/2023, or within ninety (90) calendar days for existing members. The career profile typically occurs over 2-3 sessions by the IPS employment specialist.

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The career profile will be reviewed and updated at least every six (6) months, or more often as may be appropriate to the needs of each member. Refusals to participate in and complete the career profile assessment process shall be documented within the case notes, showing efforts to engage and clinically appropriate reasons for non-completion.

The LOCUS and psychiatric evaluation will be updated at least every six (6) months or as needed based on the needs of each member, with an additional LOCUS score being completed prior to discharge.

For members participating in FACT, the assessment will include items related to court orders, identified within thirty (30) days of admission and updated every ninety (90) days or as new court orders are received.

Treatment Plan

A treatment plan, responsive to the member’s preferences and choices must be developed and in place at the time services are rendered. The treatment plan will include input from all staff involved in treatment of the member, as well as involvement of the member and collateral others of the member’s choosing. In addition, the plan must contain the signature of the psychiatrist, the team leader involved in the treatment, and the member’s signature. Refusals must be documented. The treatment plan must integrate mental health and substance use services for members with co-occurring disorders. The treatment plan will be updated every three (3) months or more often as needed based on the needs of each member.

For members participating in FACT, the treatment plan will include items relevant for any specialized interventions, such as linkages with the forensic system for members involved in the judicial system.

Treatment plan development will include an exploration of the member’s employment interests and shall be documented in the progress notes. For those individuals interested in employment, their treatment plan will include at least one vocational goal pertaining to job search, job placement, job supports, career development, or career advancement.

A tracking system is expected of each ACT team for services and time rendered for or on behalf of any member.

Each treatment plan must consist of the following:

1. Plans to address all psychiatric conditions;

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2. The member’s treatment goals and objectives (including target dates), preferred treatment approaches, and related services;
3. The member’s educational, vocational, social, wellness management, residential or recreational goals, associated concrete and measurable objectives, and related services;
4. The member’s goals and plans, and concrete and measurable objectives necessary for a person to get and keep their housing; and
5. A crisis/relapse prevention plan, including an advance directive.

When psycho-pharmacological treatment is used, a specific treatment plan, including identification of target symptoms, medication, doses and strategies to monitor and promote commitment to medication must be used.

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:

1. Crisis assessment and intervention;
2. Symptom management;
3. Individual counseling;
4. Medication administration, monitoring, education, and documentation;
5. 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;
6. 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;
7. Peer support, supporting strategies for symptom/behavior management. This occurs through providing expertise about the recovery process, peer counseling to

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members with their families, as well as other rehabilitation and support functions as coordinated within the context of a comprehensive treatment plan;

8. Addiction treatment and education, including counseling, relapse prevention, harm reduction, anger and stress management;
9. 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;
10. Education, support, and consultation to members’ families and other major supports;
11. 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;
12. Assist the member in applying for benefits. At a minimum, this includes Social Security Income, Medicaid and Patient Assistance Program enrollment;
13. 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; and
14. IPS services including ongoing exploration of employment interest, job search, job placement, job coaching, and follow-along supports.

Documentation shall be consistent with the Dartmouth Assertive Community Treatment Scale (DACTS), and the SAMHSA toolkit for ACT.

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, shall begin the process to transition into a lower level of care. When making this determination, considerations shall 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.

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ACT teams must formally assess member's needs for ACT services at least once every six (6) months using the ACT Transition Assessment Scale, a tool that establishes criteria to help determine whether a member is ready to be placed on a graduation track to transition to a less intensive level of care. An individual may be placed within the graduation track if they are assessed at a one (1) or two (2) on all the scaled items. Graduations shall also be considered for individuals assessed at a one (1) or two (2) on all scaled items but assessed at a three (3) on the Activities of Daily Living item and three (3) or four (4) on the Community Integration item. Further, assess the member's Motivation to Graduate or Transition from ACT, again considering graduations for individuals assessed at a three (3) or four (4) on this item. Teams are encouraged to continually assess the service needs of participants as the member's needs change.

It is imperative that graduation be gradual, planned and individualized with assured continuity of care. More specifically, ACT teams shall employ the following strategies regarding graduations:

1. Introduce the idea of graduation from the very beginning of the member's enrollment (even during the engagement phase) and continue the discussion throughout their enrollment;
2. Frame graduation within the larger process of the member's recovery, enhanced well-being and independence in life;
3. Involve ACT team members in a discussion of the individual's potential for graduation and plans necessary to ensure successful transition to a less intensive level of care;
4. Involve the member in all plans related to their graduation;
5. Assess the member's motivation for transition to the graduation track and provide motivational interviewing interventions as appropriate to increase their comfort and interest in the graduation;
6. Be prepared with appropriate interventions should the member temporarily experience an increase in symptoms or begin to "backslide" on treatment goals in response to graduation plans;
7. Involve the member's social network, including their family or support of choice, in developing and reviewing their graduation plan to the extent approved by the participant;

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8. Coordinate several meetings with member, relevant ACT team members, and new service provider to introduce the new provider as well as review the participant's current status, progress in ACT and future goals;
9. Temporarily overlap ACT services with those of new provider for 30-60 days; and
10. Monitor the member's status following transition and assist the new provider, as needed, especially for the next 30-60 days.

Teams shall ensure member participation in discharge activities, as evidenced by the following documentation:

1. The reasons for discharge as stated by the member and ACT team;
2. The participant's biopsychosocial status at discharge;
3. A written final evaluation summary of the member's progress toward the goals set forth in the person-centered treatment plan;
4. A plan developed in conjunction with the member for follow-up treatment after discharge; and
5. The signature of the member, their primary practitioner, the team leader and the psychiatric prescriber.

When clinically necessary, the team will make provisions for the expedited re-entry of discharged members as rapidly as possible. If immediate re-admission to the ACT team is not possible because of a full census, the provider will prioritize members who have graduated but need readmission to ACT.

Program requirements

ACT services must be provided by an interdisciplinary team capable of providing the following:

1. Service coordination;
2. Crisis assessment and intervention;
3. Symptom assessment and management;

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4. Individual counseling and psychotherapy;
5. Medication prescription, administration, monitoring and documentation;
6. Substance use treatment;
7. Rehabilitation services to restore capacity to manage activities of daily living;
8. Restoration of social, interpersonal relationship, and other skills needed to ensure the development of meaningful daily activities. This can occur through the provision of IPS services to support work and educational efforts in addition to linking to leisure activities; and
9. Direct assistance to ensure that members obtain supportive housing, as needed.

ACT is a medical psychosocial intervention program provided on the basis of the following principles:

1. The service is available twenty-four (24) hours a day, seven (7) days a week;
2. An individualized treatment plan and supports are developed;
3. At least ninety percent (90%) of services are delivered as community-based outreach services;
4. An array of services are provided based on the member’s medical need;
5. The service is member-directed; and
6. The service is recovery-oriented.

The ACT team must:

1. Operate a continuous after-hours on-call system with staff that is experienced in the program and skilled in crisis intervention (CI) procedures. The ACT team must have the capacity to respond rapidly to emergencies, both in person and by telephone;
2. Provide mobilized CI in various environments, such as the member’s home, schools, jails, homeless shelters, streets and other locations;

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3. Arrange or assist members to make a housing application, meet their housing obligations and gain the skills necessary to maintain their home;
4. Be involved in psychiatric hospital admissions and discharges and actively collaborate with inpatient treatment staff;
5. Ensure provision of culturally competent services; and
6. Conduct ongoing monitoring and evaluation of program implementation through the collection of process and outcome measures, including the following:
 - a. Process measures related to ACT programming shall be obtained through utilization of the Dartmouth Assertive Community Treatment Scale (DACTS) and General Organizational Index (GOI);
 - b. Concurrent to this process, fidelity to IPS programming shall be evaluated utilizing the Supported Employment Fidelity Scale found at <https://ipsworks.org/wp-content/uploads/2017/08/IPS-Fidelity-Scale-Eng1.pdf>; and
 - c. Outcome measures shall be collected via a standardized outcomes reporting instrument which is provided by and submitted to the MCOs monthly.

The ACT program provides three levels of interaction with the participating members, including:

1. 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 shall 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;
2. Collateral encounter – Collateral refers to members of the member’s family or household or significant others (e.g., landlord or property manager, criminal justice staff and employer) who regularly interact with the member and are directly affected by, or have the capability of affecting, their condition and are identified in the treatment plan as having a role in treatment. A collateral contact does not

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include contacts with other mental health service providers or individuals who are providing a paid service that would ordinarily be provided by the ACT team (e.g., meeting with a shelter staff person who is assisting an ACT member in locating housing); and

3. Assertive outreach – Refers to the ACT team being ‘assertive’ about knowing what is going on with a member and acting quickly and decisively when action is called for, while increasing member independence. The team must closely monitor the relationships that the member has within the community and intervene early if difficulty arises.

For those members transitioning from psychiatric or nursing facilities, ACT staff must provide a minimum of four (4) 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.

The teams will provide comprehensive, individualized services, in an integrated, continuous fashion, through a collaborative relationship with the member. The ACT program utilizes a treatment model that is non-confrontational, follows behavioral principles, considers interactions of mental illness and substance use and has gradual expectations for abstinence.

ACT teams will utilize IPS, an evidence-based supported employment model that is based upon eight basic principles that include the following:

1. Open to anyone who wants to work;
2. Focus on competitive employment;
3. Rapid job search;
4. Targeted job development;
5. Client preferences guide decisions;
6. Individualized long-term supports;
7. Integrated with treatment; and
8. Benefits counseling provided.

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Each IPS Specialist carries out all phases of employment services; including completion of career profile, job search plan, job placement, job coaching, and follow-along supports before step-down from IPS into ongoing follow along provided through the ACT team through traditional service provision.

Members are not asked to complete any vocational evaluations, i.e. paper and pencil vocational tests, interest inventories, work samples, or situational assessments, or other types of assessment in order to receive assistance obtaining a competitive job.

A career profile is typically completed during 2-3 sessions, and should include information about the member’s preferences, experiences, skills, strengths, personal contacts, etc. The career profile is reviewed and updated as needed with each new job experience and/or at least every six (6) months. The information may be provided by the member, treatment team, medical records, and with the member’s permission, from family members, and previous employers. For new admissions, the initial career profile must be completed within thirty (30) days after admission to the ACT program.

For those individuals who have expressed an interest in employment, an individualized job search plan is developed with the member, and is updated with information from the career profile, and new job experiences. IPS specialists will visit employers systematically, based upon the member’s preferences, to learn about the employer’s needs and hiring preferences. Each IPS Specialist is to make at least six (6) face-to-face employer contacts per week, whether or not the member is present. IPS Specialist are to use a weekly tracking form to document their employer contacts. The first face-to-face contact with an employer by the member or the IPS Specialist shall occur within 30 days of the member entering the program.

IPS Specialists are to have a face-to-face meeting with the member within one (1) week before starting a job, within three (3) days after starting a job, weekly for the first month, and at least monthly for a year or more, on average, after working steadily, and desired by members. At this time, members are to be transitioned to step down job supports from a mental health worker following steady employment. If a need arises for more intense support by the IPS specialist, they will increase the number of interactions with the member.

IPS specialists contact members within three (3) days of learning about the job loss. IPS specialists also provide employer support (e.g., educational information, job accommodations) at a member’s request.

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IPS provides assistance to find another job, when one job has ended, regardless of the reason the job ended, or the number of jobs the member has had. Each job is viewed as a learning experience, and offers to help find a new job is based upon the lessons learned.

Job supports are individualized and continue for as long as the member wants and needs the support. Members receive different types of support based upon the job, member preferences, work history, and needs. The IPS Specialist may also assist the member to obtain the job accommodations necessary for the member to perform the job efficiently and effectively.

IPS Specialists ensure that members are offered comprehensive and personalized benefits planning, including information about how their work may affect their disability and government benefits, as both are based upon their income. These may include medical benefits, medication subsidies, housing subsidies, food stamps, spouse and dependent children benefits, past job retirement benefits, and other sources of income.

Service termination is not based on missed appointments or fixed time limits.

Engagement and outreach attempts made by integrated ACT team members are systematically documented, including multiple home/community visits, coordinated visits by IPS specialist with integrated ACT team member, and contacts with family, when applicable. Once it is clear that the member no longer wants to work or continue with IPS services, the IPS Specialist shall review and update the career profile as needed every six (6) months; employment shall be screened every three (3) months as the treatment plan is updated.

Provider Qualifications and Responsibilities

ACT agencies must be licensed 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 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 eighteen (18) months of the initial accreditation application date. ACT Agencies contracted with a managed care entity prior to March 14, 2017, must attain full

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accreditation by September 14, 2018, i.e. eighteen (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. This includes successful completion of an LDH-approved Person Centered Planning training facilitated by the MCOs. New staff must complete the training within sixty (60) days of hire. Existing staff must complete the training by 6/30/24.

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.

Each ACT team shall have sufficient numbers of staff to provide treatment, rehabilitation and support services twenty-four (24) hours a day, seven (7) days per week. Each ACT team shall have the capacity to provide the frequency and duration of staff-to-program member contact required by each member's treatment plan.

Each ACT team shall have the capacity to increase and decrease contacts based upon daily knowledge of the member's clinical need, with a goal of maximizing independence. The team shall have the capacity to provide multiple contacts to persons in high need and a rapid response to early signs of relapse. The nature and intensity of ACT services are adjusted through the process of daily team meetings. IPS specialists shall participate in these meetings at least weekly.

Each ACT team shall have a staff-to-member ratio that does not exceed 1:10. Any ACT team vacancies that occur will be filled in a timely manner to ensure that these ratios are maintained. All professional staff must be currently and appropriately licensed by the applicable professional board. Prior to providing the service, each staff member receives training on the skills and competencies necessary to provide ACT services. Each staff member must meet the required skills and competencies within six months of their employment on an ACT team. Successful completion of LDH-approved trainings can satisfy this requirement.

Each ACT team shall include at least:

1. One (1) ACT team leader, who is a full time Licensed Mental Health Professional (LMHP) who must have both administrative and clinical skills;

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2. 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;

Note: In the event a medical psychologist or APRN are utilized, the team must be able to consult with psychiatrists.

3. 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;
4. One other LMHP;
5. One substance use specialist, who has a minimum of one (1) year specialized substance use training or supervised experience;
6. One IPS specialist, who has successfully completed the OBH-approved IPS training prior to providing IPS services; at least one (1) year of specialized training or supervised experience;
7. One housing specialist, who has at least one (1) year of specialized training or supervised experience;
8. 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 recognition requirements as a peer specialist; and
9. One IPS supervisor who has successfully completed the LDH-approved IPS training.
 - a. This shall be a .20 FTE regardless of team size;
 - b. This function can be fulfilled by the Team Leader; or an individual who supervises IPS specialists working within multiple ACT teams; and
 - c. At least one (1) year experience in employment services, which includes any experience where they have worked in programs where they helped people find jobs.

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In light of workforce shortages subsequent to the COVID-19 public health emergency, temporary modifications of these staffing requirements can occur in the event of employee turnover. However, ACT teams shall notify the MCOs in writing in the event of loss of staff and provide them with a written Corrective Action Plan for filling the position and ensuring member services are not impacted. This shall occur within seven (7) calendar days of staff separation. When the position is filled and the CAP can be lifted, the ACT team shall provide written notification of such to the MCO. Staffing levels shall increase proportional to the number of members served by the team in congruence with standards outlined within the DACTS.

ACT teams must meet national fidelity standards as outline within the SAMHSA Assertive Community Treatment (ACT) Evidence-Based Practices (EBP) Toolkit.

Teams shall adhere to the following:

1. New teams:
 - a. The ACT provider must notify the MCO in writing of its desire to create an additional team, including in this notification: justification for the creation of a new team and geographical location where the new team will operate.
 - i. The MCO will investigate the need for an ACT team in the proposed geographic location and will inform the ACT provider in writing of the MCO’s decision to approve or deny. If the MCO gives the ACT provider the approval to establish a new team, the provider will be required to follow the standard contracting/credentialing process with the MCOs in order to render services.
 - b. The ACT provider must submit documentation to the MCO for contracting purposes including evidence of fidelity to the model including findings of self-evaluation using the DACTS/General Organizational Index (GOI) in addition to submitting the appropriate credentialing materials for vetting purposes and contact the MCO to ensure that all credentialing verification steps are met.
 - i. 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.
 - c. The provider must also adhere to the following related to newly established teams:

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- i. Submit monthly outcomes reporting to the MCOs via a template provided by the MCOs.
- ii. Undergo a fidelity review using the DACTS/GOI and the Supported Employment Fidelity Scale by an MCO-identified third party within six (6) months of implementation:
 - 1. 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, be eligible to provide Medicaid funded services to members, and increase staff-to-member ratios;
 - 2. If the MCO identifies a potential Quality of Care concern based on the data from the monthly Outcome Measures report the team may be subject to corrective action. 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; and
 - 3. If the fidelity review findings does not reflect a minimum overall score of 3.0 on the DACTS/GOI, the provider will forfeit any new referrals until an overall score of 3.0 is achieved. The provider will be permitted to work with existing members as long as there are no health and safety violations with operations as determined by the MCO or LDH. The team shall implement a remediation plan and undergo another fidelity review within three (3) months by the fidelity monitor. This review will be at the cost of the provider. If the team achieves an overall score of 3.0 or greater on the DACTS/GOI in the subsequent review, the team can begin accepting new referrals;
 - 4. The Supported Employment Fidelity Scale review must reflect continued improvement toward the desired score of 100 (good fidelity); and

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5. The team will implement an MCO approved corrective action plan immediately for any individual Supported Employment Fidelity Scale criterion that rates below 100 (good fidelity). This plan must be implemented within thirty (30) days of findings or sooner as determined necessary by the MCO to mitigate health and safety issues for members.
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2. Existing teams:
 - a. Must submit monthly outcomes reporting to MCOs via a template provided by the MCOs;
 - b. 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;
 - c. The team will implement an MCO approved corrective action plan immediately for any individual DACTS criterion that rates a one (1) or two (2);
 - d. Must undergo a fidelity review using the Support Employment Fidelity Scale by an MCO-identified third party in conjunction with the DACTS/GOI fidelity review;
 - i. This review must reflect continued improvement toward the desired score of 100 (good fidelity);
 - ii. The team will implement an MCO approved corrective action plan immediately for any individual Supported Employment Fidelity Scale criterion that rates below 100 (good fidelity). This plan must be implemented within thirty (30) days of findings or sooner as determined necessary by the MCO to mitigate health and safety issues for members.
 - e. Must achieve a score of 3.0 and above on the DACTS/GOI in order to maintain certification and the ability to accept new clients;
 - f. If a score of 4.2 or higher on the DACTS/GOI is achieved, the team will be deemed as operating with “exceptional practice”:

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ASSERTIVE COMMUNITY TREATMENT

- i. MCOs may grant extensions of eighteen (18) month intervals between fidelity reviews for teams operating with “exceptional practice”.

- e. Operating below acceptable fidelity thresholds:
 - i. 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;

 - ii. Teams shall implement a remediation plan and undergo another fidelity review within three (3) months by the MCO or designee. This review will be at the cost of the provider. If the team achieves an overall score of 3.0 or greater on the DACTS/GOI in the subsequent review, the team can begin accepting new referrals; and

 - iii. If the team achieves more than a 3.0 on the DACTS/GOI in subsequent review, the team can begin accepting new referrals.

Allowed Provider Types and Specialties

PT AA Assertive Community Treatment Team, PS 8E CSoc/Behavioral Health.

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.

Exclusions

ACT services are comprehensive of all other services, with the exception of psychological evaluation or assessment and medication management. These may be provided and billed separately for a member receiving ACT services.

ACT shall not be billed in conjunction with the following services:

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1. Behavioral health (BH) services by licensed and unlicensed individuals, other than medication management and assessment; or
2. Residential services, including professional resource family care.

Billing

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.

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

1. Time spent doing, attending, or participating in recreational activities;
2. 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;
3. Habilitative services for the adult to acquire, retain, and improve the self-help, socialization and adaptive skills necessary to reside successfully in community settings;
4. Child care services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision;
5. Respite care;
6. Transportation for the individual or the individual’s family. Services provided in the car are considered transportation;
7. Services provided to individuals under the age of 18;
8. Covered services that have not been rendered;
9. Services provided before approved authorization;
10. Services rendered that are not in accordance with an approved authorization;

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11. Services not identified on the authorized treatment plan;
12. Services provided without prior authorization;
13. 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;
14. Services provided that are not within the provider's scope of practice;
15. Any art, movement, dance, or drama therapies; and
16. Anything not included in the approved ACT services description.

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**FUNCTIONAL FAMILY THERAPY (FFT) AND
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The provider agency must have a current certification issued by the Institute for Functional Family Therapy (FFT), Inc. The licensed entity has agreed to assume responsibility for this service under its license. The provider contracts with FFT, Inc. for training, supervision and monitoring of services. This occurs primarily through a FFT national consultant. The provider will also have a contractual relationship with FFT, Inc., allowing the provider to deliver the licensed FFT model.

FFT services are targeted for youth primarily demonstrating externalizing behaviors or at risk for developing more severe behaviors, which affect family functioning. Youth behaviors include antisocial behavior or acts, violent behaviors and other behavioral issues that impair functioning. Youth may also meet criteria for a disruptive behavior disorder (attention deficit/hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), and/or conduct disorder). Youth with other mental health conditions, such as anxiety and depression, may also be accepted as long as the existing mental and behavioral health (BH) issues manifest in outward behaviors that impact the family and multiple systems. Youth with substance use issues may be included if they meet the criteria below, and FFT is deemed clinically more appropriate than focused drug and alcohol treatment. However, acting out behaviors must be present to the degree that functioning is impaired and the following terms are met:

1. Youth, ages 10-18, typically referred by other service providers and agencies on behalf of the youth and family, though other referral sources are also appropriate;
2. At least one adult caregiver is available to provide support and is willing to be involved in treatment;
3. A DSM-5 diagnosis as primary focus of treatment. Symptoms and impairment must be the result of a primary disruptive/externalizing behavior disorder, although internalizing psychiatric conditions and substance use disorders may be secondary;
4. Functional impairment not solely a result of an autism spectrum disorder or intellectual disability;

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5. Youth displays externalizing behavior, which adversely affects family functioning. Youth’s behaviors may also affect functioning in other systems; and
6. Documented medical necessity for an intensive in-home service.

Functional Family Therapy – Child Welfare (FFT-CW) services are targeted for youth and families with suspected or indicated child abuse or neglect. Problems include youth truancy, educational neglect, parental neglect or abuse, a history of domestic violence, adult caregiver substance use, and adult caregiver anxiety, depression and other mental health issues. Youth may also meet criteria for a disruptive behavior disorder (ADHD, ODD, and/or conduct disorder). Youth with other mental health conditions, such as anxiety and depression, may also be accepted as long as the existing mental and BH issues manifest in outward behaviors that impact the family and multiple systems. Youth with substance use issues may be included if they meet the criteria below, and FFT-CW is deemed clinically more appropriate than focused drug and alcohol treatment. However, acting out behaviors must be present to the degree that functioning is impaired and the following terms are met:

1. Families of youth, ages 0-18, typically referred by other service providers and agencies on behalf of the youth and family, though other referral sources are also appropriate;
2. At least one adult caregiver is available to provide support and is willing to be involved in treatment;
3. DSM-5 diagnosis as primary focus of treatment. Symptoms and impairment must be the result of a primary disruptive/externalizing behavior disorder or internalizing psychiatric conditions and substance use. Diagnosis can be for youth or caregiver;
4. Functional impairment not solely a result of an autism spectrum disorder or intellectual disability; and
5. Documented medical necessity for an intensive in-home service.

FFT and FFT-CW are deemed a best practice/family-based approach to providing treatment to youth who are between the ages of 10 and 18 (0 to 18 for FFT-CW) and are exhibiting significant

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externalizing behaviors. It is a systems-based model of intervention/prevention, which incorporates various levels of the member’s interpersonal experiences to include cognitive, emotional and behavioral experiences, as well as intrapersonal perspectives which focus on the family and other systems (within the environment) and impact the youth and their family system. FFT/FFT-CW is a strengths-based model of intervention, which emphasizes the capitalization of the resources of the youth, their family and those of the multi-system involved. Its purpose is to foster resilience and ultimately decrease incidents of disruptive behavior for the youth. More specifically, some of the goals of the service are to reduce intense/ negative behavioral patterns, improve family communication, parenting practices and problem-solving skill, and increase the family’s ability to access community resources.

The FFT/FFT-CW model of intervention/prevention is based on three core principles for understanding the following three components of the treatment: the members who are served, the problems the youth and families are faced with and the process of providing the therapeutic service. More specifically, the three core principles are defined as follows:

1. **Core Principle One: Understanding members:**
This is a process whereby the therapist comes to understand the youth and family in terms of their strengths on the individual, family system and multi-systemic level;
2. **Core Principle Two: Understanding the member systemically:**
This is a process whereby the therapist conceptualizes the youth’s behaviors in terms of their biological, relational, family, socio-economic and environmental etiology. Subsequently, the therapist assesses the youth’s relationships with family, parents, peers, their school and their environment and how these roles/relationships contribute to the maintenance and change of problematic behaviors; and
3. **Core Principle Three: Understanding therapy and the role of the therapist as a fundamentally relational process:**
This is a process where the therapist achieves a collaborative alliance with the youth and family. Subsequently, the therapist ensures that the therapy is systematic and purposeful, while maintaining clinical integrity. More specifically, the therapist follows the model but also responds to the emotional processes (needs/feelings/behaviors) that occur in the immediacy during clinical practice.

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Specific Design of the Service

On average, a youth receives FFT/FFT-CW for approximately 3 to 5 months. Over the course of this period, the therapist works with the family in twelve to fifteen one- to two-hour sessions for less severe cases and up to 30 -one- to two-hour sessions for youth with more complex needs. The frequency of the sessions varies on a case-by-case basis and over the course of the treatment; sessions could occur daily to weekly, as needed. Services occur in the office, family’s home and/or community at times that are convenient for the family. In addition to being available to families as needed (intensity is based on family risk and protective factors), FFT/FFT-CW therapists provide regular telephonic follow-up and support to families between sessions. FFT/FFT-CW is carried out in the context of five distinct phases. Each phase consists of an assessment, goal-setting and an intervention component; all services rendered are carried-out based upon the theoretical framework of the three core principles.

The intervention program itself consists of five major components, in addition to pretreatment activities: (1) Engagement; (2) Motivation to change; (3) Relational/Interpersonal assessment and planning for behavior change; (4) Behavior change; and (5) Generalization across behavioral domains and multiple systems:

1. **Pretreatment phase**

The goals of this phase involve responsive and timely referrals, a positive “mindset” of referring sources and immediacy. Activities include establishing collaborative relationships with referring sources, ensuring availability, appraising multidimensional (e.g., medical, educational, justice) systems already in place and reviewing referral and other formal assessment data;

2. **Engagement phase**

The goals of this phase involve enhancing perception of responsiveness and credibility, demonstrating a desire to listen, help, respect and “match” and addressing cultural competence. The main skills required are demonstrating qualities consistent with positive perceptions of members, persistence, cultural/population sensitivity and matching. Therapist focus is on immediate responsiveness and maintaining a strength-based relational focus. Activities include high availability, telephone outreach, appropriate language and dress,

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proximal services or adequate transportation, contact with as many family members as possible, “matching” and respectful attitude;

3. Motivation phase

The goals of this phase include creating a positive motivational context, minimizing hopelessness and low self-efficacy and changing the meaning of family relationships to emphasize possible hopeful experience. Required phase skills consist of relationship and interpersonal skills, a nonjudgmental approach, plus acceptance and sensitivity to diversity. Therapist focus is on the relationship process, separating blaming from responsibility while remaining strength-based. Activities include the interruption of highly negative interaction patterns and blaming (e.g., divert and interrupt), changing meaning through a strength-based relational focus, pointing process, sequencing and reframing of the themes by validating negative impact of behavior, while introducing possible benign/noble (but misguided) motives for behavior. Finally, the introduction of themes and sequences that imply a positive future are important activities of this phase;

4. Relational assessment phase

The goals of relational assessment include eliciting and analyzing information pertaining to relational processes, as well as developing plans for behavior change and generalization. The skills of perceptiveness and understanding relational processes and interpersonal functions are required. The focus is directed to intrafamily and extrafamily context and capacities (e.g., values, attributions, functions, interaction patterns, sources of resistance, and resources and limitations). Therapist activities involve observation, questioning; inferences regarding the functions of negative behaviors and switching from an individual problem focus to a relational perspective;

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5. Behavior change phase

Behavior change goals consist of skill building, changing habitual problematic interactions and other coping patterns. Skills, such as structuring, teaching, organizing and understanding behavioral assessment, are required. Therapists focus on communication training, using technical aids, assigning tasks and training in conflict resolution. Phase activities are focused on modeling and prompting positive behavior, providing directives and information and developing creative programs to change behavior, all while remaining sensitive to family member abilities and interpersonal needs; and

6. Generalization phase

The primary goals in the generalization phase are extending positive family functioning, planning for relapse prevention and incorporating community systems. Skills include a multi-systemic/systems understanding and the ability to establish links, maintain energy and provide outreach. The primary focus is on relationships between family members and multiple community systems. Generalization activities involve knowing the community, developing and maintain contacts, initiating clinical linkages, creating relapse prevention plans and helping the family develop independence.

Additional Points to Cover

Outreach and linkages made with community supports are an essential part of the model, particularly during pre-treatment, engagement, and generalization phases; this includes non-face-to-face and telephonic contact with these sources, with or without the member present.

Description of Individualization for Youth and Family

The FFT/FFT-CW therapist must work with any treatment planning team, including the wraparound facilitator (WF) through the Coordinated System of Care (CSoC), to develop an individualized treatment plan.

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There are four domains of assessment used to monitor progress towards goals including the following:

1. Member assessment (through the use of the outcomes questionnaire (OQ) family measures pre-assessment, risk and protective factors assessments pre-assessment, relational assessment):
 - a. Helps understand individual, family and behavior in a context functioning; and
 - b. Adds to clinical judgment, helps target behavior change targets, tool in treatment.
2. Adherence assessment (through the use of the Family Self Report and Therapist Self Report, and Clinical Services System (CSS) tracking/adherence reports, global therapist ratings):
 - a. Identifies adherence to FFT/FFTCW to enhance learning and supervision; and
 - b. Judges clinical progress, monitor clinical decisions.
3. Outcome assessment (through the use of therapist outcome measure, counseling outcome measure parent/adolescent and post assessment OQ family measures and post risk and protective factors assessment):
 - a. Helps understand the outcome of your work – accountability; and
 - b. Identifies changes in member functioning (pre-post).

NOTE: The term “counseling” throughout the FFT section is in keeping with the nomenclature of this evidenced based practice and should not be mistaken for the counseling and psychotherapy rendered by LMHPs under their respective scope of practice license.

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4. Case monitoring and tracking (member service system reports):
 - a. Every member contact/planned contact, outcome of that contact (helps monitor practice).

Cultural and Ethical Concerns

FFT/FFT-CW treatment is attuned to the importance of ethnicity and culture for all members referred for services. Cultural values and concerns are addressed in the context of the family system and the multi-systems which influence the intervention. Cultural sensitivity is an integral part of understanding the child and family from a systems perspective. FFT/FFT-CW can be carried out by therapists from diverse backgrounds. Thus, intervention involves the use of fostering resilience and identifying resources within the family systems and multi-systems. Inevitably, this will include understanding the family and multi-systems within the context of their cultural backgrounds.

Child Integration to Community

The treatment objectives demonstrate that FFT/FFT-CW focuses on fostering resilience for youth and family and capitalizing on resources within the family system and multi-systems (to include the community). Thus, in order to achieve generalization, the youth and family need to demonstrate their ability to utilize resources within the community and demonstrate integration prior to discharge.

The FFT/FFT-CW model is consistent with the Child and Adolescent Services System Program principles, which are critical treatment standards important to all families in Louisiana. For example, by maintaining the youth within the community, the least restrictive environment, FFT/FFT-CW treatment interventions strengthen the family and youth’s relationship with community resources and the people managing them. This is important for creating sustainable treatment outcomes. FFT/FFT-CW is delivered as an in-home community-based service. FFT/FFT-CW clinicians cannot directly bill for travel time.

Provider Qualifications and Responsibilities

FFT/FFT-CW agencies must be licensed pursuant to La. R.S. 40:2151, et. seq. for behavioral health service providers and certified by the Institute for FFT, LLC. The provider agency must meet all qualifications as required for other outpatient and rehabilitation agencies and must

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maintain documentation and verification of licensure, certification through the Institute for FFT, LLC, staff criminal background checks, TB testing, drug testing and required training for staff employed or contracted with the agency. FFT/FFT-CW-only agencies are not required to be accredited due to the extensive nature of consultation by the Institute for FFT. These agencies must maintain good standing with the Institute for FFT, ensure fidelity to the FFT/FFT-CW model and maintain licensure through the Louisiana Department of Health (LDH).

NOTE: Agencies providing non-EBP rehabilitation and/or addiction services in addition to FFT/FFT-CW must be accredited by an LDH approved national accrediting body: Commission on Accreditation of Rehabilitation Facilities (CARF), Council on Accreditation (COA), or The Joint Commission (TJC).

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 include the following:

1. Behavioral Health Service Providers (BHSPs) **exclusively** providing the evidence-based practice Functional Family Therapy (FFT/FFT-CW), 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/FFT-CW), 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 requirements detailed in

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this manual chapter under *Provider Responsibilities* in Section 2.3 – Outpatient Services – Rehabilitation Services for Children, Adolescents, and Adults.

Allowed Provider Types and Specialties

1. PT 77 Mental Health Rehab PS 78 MHR; and
2. PT 74 Mental Health Clinic PS 70 Clinic / Group PSS 8E CSoC/ Behavioral Health.

Staff education level/qualifications and training topics

Education/qualifications

FFT/FFT-CW Therapists

The FFT/FFT-CW program at the provider level will consist of one site. This site will be comprised of (three to eight) therapists. Therapists are master’s-level staff with graduate degrees in a clinical field. Other human service degrees may be accepted. Highly skilled bachelor’s-level professionals may also be selected under certain hiring conditions. These conditions include: (1) the provider has actively recruited for master’s-level therapists but has not found any acceptable candidates or the bachelor’s-level applicant is clearly better qualified than the master’s-level applicants and (2) the bachelor’s degree must be in a human services field. A degree in a mental health field is preferred.

NOTE: The term “therapist” is in keeping with the nomenclature of this evidenced based practice and should not be mistaken for licensed mental health professionals (LMHPs), who provide counseling and psychotherapy under their respective scope of practice license.

All FFT/FFT-CW therapists must have a background in family, youth and community service and a minimum of two years’ experience working with children, adolescents and families. FFT/FFTCW therapists will meet the guidelines for training outlined below.

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FFT Site Supervisor

At the cessation of Phase One, (approximately nine to twelve months after the initial training) the FFT/FFT-CW site supervisor is expected to emerge and be appointed. The site can appoint a site supervisor prior to the cessation of Phase Two; however, it is expected that, regardless, this person follow FFT/FFT-CW training guidelines which are outlined below.

Site supervisors are master’s-level mental health professionals with graduate degrees in a clinical discipline. A background in family, youth and community service and a minimum of two years’ experience working in these areas is required.

FFT National Consultant

The provider will work with a FFT national consultant, who will provide the monitoring, supervision, and training during the first two phases (typically the first two years) of site implementation. This person will have been involved in the delivery of FFT services for five years, has been a site supervisor, had training and is employed by FFT, LLC.

Note: FFT/FFT-CW provider agencies are required to employee or contract with an LMHP as a BHS organizational requirement of LDH. Utilization of the FFT/FFT-CW Supervisor does not exempt FFT/FFTCW agencies from this requirement.

All staff will have background checks, TB testing, screenings and required trainings on file before working with youth and families.

Training

FFT/FFT-CW services must maintain treatment integrity and meet fidelity criteria developed by FFT, Inc. FFT/FFT-CW fidelity is achieved through a specific training model and a sophisticated member assessment, tracking, and monitoring system that provides for specific clinical assessment and outcome accountability. FFT therapists maintain fidelity by regularly staffing cases, attending follow-up trainings, and participating in individual and group supervision. FFT/FFT-CW clinical supervisors participate in regular consultation with a National FFT, Inc. consultant.

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The following is the process the provider will use to become an approved site by FFT, LLC. This training regimen will be completed in order to ensure fidelity to the FFT/FFTCW model:

1. The provider will appoint individual therapists who have met the criteria for education and qualifications outlined above;
2. After the provider has identified appropriate staff, they will call FFT, LLC. to set-up the initial one-day orientation training. The provider has arranged for their team and all stakeholders to attend in order to learn the process of referring youth for FFT/FFT-CW in the providers' particular community. During this training, the site members will have learned successful implementation of FFT/FFT-CW to include use of assessment tools and protocols and the use of the CSS. At the cessation of this training, the provider will have agreed to have at least five referrals for FFT/FFT-CW for each team member to begin with after they have completed the next training session, which is the initial clinical training (CT1);
3. Approximately one to two weeks after the initial one-day orientation training, the provider will arrange to have all FFT/FFT-CW therapists attend the CT1 training. This will be conducted over a two-day period and be carried out on the site of the provider. An FFT developer or national consultant will conduct this training;
4. Six weeks post CT1, the site is eligible for site certification;
5. Immediately following the initial training, the therapists at the provider sites will begin to see their cases and engage in weekly supervision with the FFT national consultant. Each weekly supervision session will be conducted for approximately one hour. The National consultant will use a staffing procedure which reinforces the model, will review all CSS paperwork and provide feedback to the team or teams. In addition, the provider will ensure that the FFT/FFT-CW team/teams are meeting for an additional hour per week for peer supervision;
6. At six weeks, four to five months, and eight to ten months after the initial clinical training, the FFT national consultant will come to the provider's site and complete two-day follow-up trainings. All FFT/FFT-CW therapists employed by the provider

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will attend the follow-up trainings. The purpose of these follow-up trainings will be to review phase goals and assessments, update therapists on current events or changes and to provide specialized training to the team in regard to their specific cases;

7. At six months following CT1, the provider’s FFT/FFT-CW team/teams will attend the second clinical training (CT2). This will be conducted by the FFT developers or the national consultant. (Please note this is a new requirement by FFT, LLC.);
8. At approximately nine months, a lead should emerge or have been appointed, who will serve as the FFT/FFT-CW supervisor. The provider will ensure that this staff member attends the FFT/FFT-CW externship. This externship will consist of three, three-day trainings occurring every month during the duration of the externship. This training will be conducted by FFT/FFT-CW externship trainers. At the cessation of this externship, it will be determined whether the selected FFT/FFT-CW supervisor will continue to serve in this role;
9. Once the site supervisor has completed the externship and is deemed qualified, the provider will be considered to be in Phase Two (approximately Year Two). At this time, the provider will ensure that the supervisor attends supervision trainings (two trainings), and they will begin taking over the supervision of the FFT/FFT-CW therapists. The site supervisor and therapists will also take part in one two-day training session conducted on site by the FFT national consultant; and
10. Should there be any staff turnover, the provider will ensure that new FFT/FFT-CW therapists attend the replacement trainings either in-state, if offered, or out-of-state, if need be.

Supervision

Intensive supervision and clinical consultation are an integral part of the FFT/FFT-CW model and are focused on promoting consistent application of the FFT/FFT-CW model to all cases. Supervision is built into the training protocol and certification process.

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Supervision in FFT/FFT-CW includes the following:

1. The FFT national consultant will provide the monitoring, supervision and training during the first two years of the provider’s implementation of FFT/FFT-CW:
 - a. This supervision will include one, one-hour weekly phone consult with the site during Year One of implementation; and
 - b. During Year Two, the FFT national consultant will provide two one-hour supervision sessions to the site supervisor in training.
3. During Year Two of implementation, the provider’s site supervisor will provide oversight to the therapists and will complete all required trainings outlined by FFT, LLC. The site supervisor will hold one-hour weekly sessions with the therapists;
4. FFT/FFT-CW therapists at the provider will also engage in one one-hour weekly peer supervision sessions during Year One. During Year Two, this requirement is left up to the site. Typically, the site supervisor holds one- to two-hour weekly supervisions then. Please indicate your site’s intention regarding these supervision times; and
5. Phase/Year Three is considered a maintenance phase. A national consultant is assigned to monitor the site monthly through a call with the site supervisor, and this national consultant will do one site visit per year.

Additional Supervision

Child psychiatrists and/or psychologists or medical psychologists provide consultation to the FFT/FFT-CW teams, as needed. Psychiatrists and/or psychologists are employees/subcontractors of the provider. All analysis of problem behaviors must be performed under the supervision of a licensed psychologist/medical psychologist.

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Monitoring and assessment of service delivery

The provider will assess and monitor the delivery of the FFT/FFT-CW service via the use of the CSS. This is an online data base which has been originated by FFT, LLC. The type of data collected by the CSS includes the following:

1. Assessments of risk and protective factors (Risk and Protective Factors Assessment);
2. Relationship assessments (this is embedded in the progress note);
3. Individual functioning (pre- and post-intervention) (OQ-45.2);
4. Functioning within the context of the assessments (pre- and post-intervention) YOQ 2.01 and YOQ SR;
5. Assessments of family and therapist agreement (Family Self Report and Therapist Self Report);
6. Fidelity Ratings (Weekly adherence ratings – by national consultant in Year One and by site supervisor in Year Two and beyond);
7. FFT/FFT-CW global therapist rating; and
8. Tri-yearly Performance Evaluation, which provides Completion rates, Time of drop-out, Reasons for drop-out, Caseload information, Case tracking information, Fidelity and Adherence information, Assessment Completion information.

Each FFT/FFT-CW therapist will receive a log on and password for the CSS for referencing their own members only. The provider will receive an administrator/evaluator log on and password. The FFT national consultant will also have access to the data from the CSS.

Please see the FFT website for additional information: www.fftinc.com.

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Exclusions

FFT shall not be billed in conjunction with PRTF services.

As standard practice, FFT/FFT-CW may be billed with medication management and assessment. FFT **may** also be billed in conjunction with another behavioral health service (such as individual therapy, Community Psychiatric Support and Treatment (CPST), Psychosocial Rehabilitation (PSR), or ILSB) if:

1. The youth has a high level of need such that a combination of both family-focused and individually-focused services is needed to meet the youth’s required level of treatment intensity;
2. There is a clear treatment plan or Plan of Care indicating distinct goals or objectives being addressed by both the FFT/FFT-CW service and by the concurrent service; and
3. The services are delivered in coordination of each other to ensure no overlap or contradiction in treatment.

Billing

1. Only direct staff face-to-face time with the child or family may be billed. FFT/FFT-CW may be billed 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, and the child/youth receiving treatment does not need to be present for all contacts;
2. Collateral contacts billable to Medicaid should involve contacts with parents, guardians or other individuals having a primary care relationship with the individual receiving treatment. All contacts must be based on goals from the child’s/youth’s plan of care. Phone contacts are not billable;

NOTE: The exception to the allowance of collateral contacts while providing evidence-based practices is coordination with other child-serving systems such as parole and probation programs, public guardianship programs, special education

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programs, child welfare/child protective services and foster care programs. Coordination with these child-serving systems is considered collateral contact and may be necessary to meet their goals of the individual but is not billable through Medicaid. Services may be provided by these child-serving systems, however, the services provided must be funded through the agency providing the service.

3. Time spent in travel, transporting children, documenting, supervision, training, etc. has been factored into the indirect unit cost and may not be billed directly;
4. Medicaid may not reimburse for children in the custody of the Office of Juvenile Justice (OJJ), who reside in detention facilities, public institutions or secure care and are inmates of a public institution. If the child is in OJJ custody, but not in a public correctional institution (i.e., is outpatient), Medicaid will reimburse for the FFT/FFT-CW, except for the oversight of restorative measures, which is an OJJ function;
5. Medicaid will not reimburse for services provided to children who are residents of institutions for mental diseases (IMDs), which are institutions with greater than 16 beds, where more than 50 percent of the residents require treatment for BH conditions; and
6. Medicaid does not pay when the vocational supports provided via FFT qualify for vocational rehabilitation funding, even if the vocational rehabilitation services are not available.

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The provider agency must be an approved Homebuilders provider for Louisiana. The licensed entity has agreed to assume responsibility for this service under its license. The provider contracts with Institute for Family Development (IFD) for training, supervision and monitoring of services. This occurs primarily through a Homebuilders® national consultant. IFD provides training and consultation to teams as part of a contract with the Department of Children and Family Services (DCFS). Teams are expected to maintain Homebuilders standards or they can be put on a quality improvement plan.

Homebuilders® is an intensive, in-home evidence based program (EBP) utilizing research based strategies (e.g. motivational interviewing, cognitive and behavioral interventions, relapse prevention, skills training), for families with children (birth to 18 years of age) at imminent risk of out of home placement (requires a person with placement authority to state that the child is at risk for out of home placement without Homebuilders®), or being reunified from placement.

Homebuilders® is provided through IFD. Homebuilders® participants demonstrate the following characteristics:

1. Children/youth with serious behavioral and/or emotional problems in the home, school, and/or community;
2. Family members with substance abuse problems, mental health problems, poverty-related concerns (lack of adequate housing, clothing and/or food);
3. Babies that were born substance-exposed or considered failure to thrive;
4. Teenagers/adolescents that run away from home, have suicidal risk, have attendance and/or behavioral problems at school, have drug and alcohol use, and/or experience parent-teen conflict(s); and/or
5. Children/youth who have experienced abuse, neglect, or exposures to violence or other trauma.

The primary intervention components of the Homebuilders® model are engaging and motivating family members, conducting holistic, behavioral assessments of strengths and problems, developing outcome-based goals. Therapists provide a wide range of counseling services using

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research-based motivation enhancement and cognitive behavioral interventions, teaching skills to facilitate behavior change and developing and enhancing ongoing supports and resources. In addition, therapists help families enhance their social support network and access basic needs such as food, shelter, and clothing. Homebuilders® programs have been successfully implemented in diverse and multi-ethnic/multicultural communities across the United States and other countries.

NOTE: The term “counseling” throughout the Homebuilders® section is in keeping with the nomenclature of this evidenced based practice and should not be mistaken for the counseling and psychotherapy rendered by licensed medical health professionals (LMHPs) under their respective scope of practice license.

Homebuilders® consists of the following:

1. **Intensity:** An average of eight to ten hours per week of face-to-face contact, with telephone contact between sessions. Services average 38 face-to-face hours. Therapists schedule sessions during the day, evening and on weekends with 3-5 or more sessions per week based on safety and intervention needs;
2. **Duration:** Four to six weeks. Extensions beyond four weeks must be approved by the Homebuilders consultant. Two aftercare 'booster sessions' totaling five hours are available in the six months following referral. Additional booster sessions can be approved by the Homebuilders consultant; and
3. **Crisis Intervention:** Homebuilders therapists are available 24/7 for telephone and face-to-face crisis intervention.

Target Population

The goals of Homebuilders® are to reduce child abuse and neglect, family conflict, and child behavior problems, and improve parenting skills, family interactions, and family safety to prevent the imminent need for placement or successfully reunify children.

The Homebuilders® model is designed to eliminate barriers to service while using research-based interventions to improve parental skills, parental capabilities, family interactions, children’s behavior, and well- being, family safety and the family environment.

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The children are returning from, or at risk of, placement into foster care, group or residential treatment, psychiatric hospitals or juvenile justice facilities.

Homebuilders® is specifically aimed toward children and families identified with:

1. Caregiver and/or child emotional/behavioral management problems;
2. Trauma exposure;
3. Incurability;
4. Academic problems;
5. Delinquency;
6. Truancy;
7. Running away;
8. Family conflict and violence;
9. Poor/ineffective parenting skills;
10. Single parent families;
11. Sibling antisocial behavior;
12. Parental/caregiver use of physical punishment, harsh, and/or erratic discipline practices;
13. Substance use;
14. Mental health concerns (depression/mood disorders, anxiety, etc.); and/or
15. Additional topics such as:
 - a. Poverty;

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- b. Lack of education;
- c. Substandard housing; and
- d. Lack of supports and resources.

Therapeutic Goals

The therapeutic goals of Homebuilders® are to improve parenting skills, family functioning, parent/caregiver and children’s behavior and emotion management skill, increase safety of all family members, in order for children/youth to live safely at home.

Homebuilders® includes a homework/practice component. Homework is individually tailored based on family goals; usually includes practicing skills and implementing interventions.

Core Strategies

The core program strategies are:

1. **Engagement:** Use a collaborative and collegial approach, and Motivational Interviewing to engage and motivate families;
2. **Assessment and goal setting:** Use member-directed assessment across life domains, ongoing safety assessment and planning, domestic violence assessment, suicide assessment, and crisis planning. Develop behaviorally specific and measurable goals, and specific service/treatment plans;
3. **Behavior change:** Use cognitive and behavioral research-based practices and interventions;
4. **Skills development:** Teach parents and children a wide variety of “life skills.” Use “teaching interaction” process including demonstrations, practice, feedback; utilize homework to help parents and children practice new skills between visits;

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5. **Concrete services:** Provide and/or help the family access concrete goods and services that are directly related to achieving the family’s goals, while teaching them to meet these needs on their own;
6. **Community coordination and interactions:** Coordinate, collaborate, and advocate with state, local, public, and community services and systems affecting the family, while teaching members to advocate and access support for themselves;
7. **Immediate response to referral:** Accept referrals 24 hours a day, 7 days a week. Therapist and Supervisor are available 24-hours a day, 7 days a week;
8. **Service provided in the natural environment:** Provide services in the families’ homes and community;
9. **Caseload size:** Carry caseloads of two families at a time on average;
10. **Flexibility and responsiveness:** Tailor services and sessions to each family’s needs, strengths, lifestyle, and culture;
11. **Time-limited and low caseload:** Families receive four to six weeks of intensive intervention with up to two “booster sessions”. Therapists typically serve two families at a time and provide 80 to100 hours of service, with an average of 38 hours of face-to-face contact with the family;
12. **Strengths-based:** Therapists help members identify and prioritize goals, strengths and values and help them use and enhance strengths and resources to achieve their goals;
13. **Ecological/holistic assessment and individualized treatment planning:** Assessments of family strengths, problems and barriers to service/treatment and outcome-based goals and treatment plans utilized with each family;
14. **Research-based treatment practices:** Therapists use evidence-based treatment practices, including motivational interviewing, behavioral parent training, cognitive behavioral therapy (CBT) strategies and relapse prevention. Therapists teach family members a variety of skills, including child behavior management, effective discipline, positive behavioral support, communication skills, problem-

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solving skills, resisting peer pressure, mood management skills, safety planning and establishing daily routines;

15. **Support and resource building:** Therapists help families assess their formal and informal supports and develop and enhance ongoing supports and resources for maintaining and facilitating changes; and
16. **Critical thinking framework:** Therapists, supervisors and managers use a critical thinking framework for assessing, planning, implementing and evaluating progress and outcomes.

The North Carolina Family Assessment Scale (NCFAS or NCFAS-R R for reunification cases) is a tool utilized during treatment to summarize the overall assessment, and is used as a pre/post measurement tool to observe change, and to guide the service plan created for treatment.

Limitations

When Homebuilders® is utilized for clinical goals of a Medicaid eligible individual, Medicaid will reimburse. When Homebuilders® is utilized for the clinical goals of a non-Medicaid individual or other goals consistent with the Homebuilders® model, the referring agency or the family will reimburse. Homebuilders® may also be used for stabilization referrals where children are transitioning from a more restrictive to a less restrictive placement (such as a move from a group home to foster home or relative, only for stabilization purposes) or may be used for to stabilize a foster placement that is at risk of dissolution as long as the child demonstrates the listed characteristics.

Provider Qualifications and Responsibilities

Homebuilders® agencies must be licensed pursuant to La. R.S. 40:2151, et. seq. for behavioral health service providers. The provider agency must meet all qualifications as required for other outpatient and rehabilitation agencies and must maintain documentation and verification of licensure, certification by IFD, staff criminal background checks, Tuberculosis (TB) testing, drug testing and required training for staff employed or contracted with the agency. Homebuilders®-only agencies are not required to be accredited due to the extensive nature of consultation by IFD. These agencies must maintain good standing with IFD, ensure fidelity to the Homebuilders® model and maintain licensure through the Louisiana Department of Health (LDH).

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NOTE: Agencies providing non-EBP rehabilitation and/or addiction services in addition to Homebuilders® must be accredited by one of the following LDH approved national accrediting bodies:

1. Commission on Accreditation of Rehabilitation Facilities (CARF);
2. Council on Accreditation (COA); or
3. The Joint Commission (TJC).

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 requirements detailed in this manual chapter under *Provider Responsibilities* in Section 2.3 – Outpatient Services – Rehabilitation Services for Children, Adolescents, and Adults.

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Allowed Provider Types and Specialties

1. PT 77 Mental Health Rehab PS 78 MHR; and

PT 74 Mental Health Clinic PS 70 Clinic / Group PSS 8E CSoC/ Behavioral Health.

Staff Education Level/Qualifications and Training Topics

Education/Qualifications

Homebuilders® Therapist

Master's degree in psychology, social work, counseling, or a related field, or Bachelor's degree in same fields plus two years of experience working with families.

NOTE: The term “therapist” is in keeping with the nomenclature of this evidenced based practice and should not be mistaken for LMHPs, who provide counseling and psychotherapy under their respective scope of practice license.

Homebuilders® Supervisor

Master's degree in psychology, social work, counseling or a related field, or Bachelor's degree in same fields plus two years of experience providing the program, plus one year supervisory/management experience.

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Training

Training includes the following steps:

Staff	Year 1	Year 2	As Needed
Therapists	11-13 days/workshop training	5-7 days/workshop training	Webinar training
Supervisors	same as therapists plus 3-5 days of supervisor workshop training	same as therapists plus 2-3 days of supervisor workshop training	Webinar training
Program Mangers	minimum of Homebuilders® Core Curriculum, Online Data Manager (ODM) training and 3-5 days of Supervisor workshop training.	minimum of 2-3 days of supervisor workshop training	Webinar training

Supervision

Weekly team consultation/supervision with the Homebuilders® consultant (via telephone or Skype), individual supervision and consultation available 24/7. Homebuilders® consultant also consults individually with the supervisor as needed, and is available for emergency consultation 24/7. Sites are required to consult with Homebuilders® consultant for specified issues. Also there is also required consultation with the supervisor or program manager for specified situations. IFD has clear guidelines for when therapists must consult with their supervisor, and when supervisors must consult with their program manager, and when Homebuilders® consultant(s) should be included.

One of the important variables impacting the overall level of consultation provided is the “level” of the supervisor. Supervisors will move to levels 3 and in level 4 they take on more of the responsibility to do their own site reviews (with our oversight), and monthly consultation time is reduced. When a team has supervisor turnover, the new supervisor starts at level 1 and the consultation moves back to level 1 oversight and consultation.

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The Homebuilders® consultants are IFD staff who have years of experience delivering, supervising and /or managing Homebuilders® programs. All are MA/MSW or Ph.D. licensed (in Mental Health Counseling, Social Work or Marriage and Family). The range of Homebuilders® experience for the consultants is 8 to over 30. The consultants also deliver Homebuilders® training through the US and in other countries.

Monitoring and Assessment of Service Delivery

All programs are required to use the web-based member documentation and data system (ODM). All member documentation is entered (with guidelines about when this occurs) into ODM, and data reports are generated from the information that go into part of the fidelity and site reviews.

Site Reviews

There are two (2) onsite visits a year, as follows:

1. A mid-year review (go on home visits, observe team consultation, meet with administrators, etc.), with only quantitative data run and reported; and
2. A year-end full-site review (visit with home visits, team consultation reviews, file reviews, etc.) – After full site reports are completed, Professional Development Plans (PDPs) and Quality Enhancement Plans (QE plans) are developed after.

IFD supports the creation of PDPs for individuals and QE plans for the team. When/if serious problems occur Quality Improvement plans (QI plans) are developed and are time limited, and can result in individual or teams not being allowed to deliver Homebuilders®. Please visit the following website for more information: www.institutefamily.org

Exclusions

Homebuilders® services are comprehensive of all other services, with the exception of psychological evaluation or assessment and medication management. These may be provided and billed separately for a member receiving Homebuilders® services.

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**APPENDIX E-3: EVIDENCED BASED PRACTICES (EBPs) POLICY –
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Homebuilders® shall not be billed in conjunction with the following services:

1. Behavioral health (BH) services by licensed and unlicensed individuals, other than medication management and assessment; and
2. Residential services, including professional resource family care.

Billing

1. Only direct staff face-to-face time with the child or family may be billed. Homebuilders® may be billed for under community psychiatric supportive treatment (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, and the child/youth receiving treatment does not need to be present for all contacts;
2. Collateral contacts billable to Medicaid should involve contacts with parents, guardians or other individuals having a primary care relationship with the individual receiving treatment. All contacts must be based on goals from the child’s/youth’s plan of care. Phone contacts are not billable;

NOTE: The exception to the allowance of collateral contacts while providing evidence-based practices is coordination with other child-serving systems such as parole and probation programs, public guardianship programs, special education programs, child welfare/child protective services and foster care programs. Coordination with these child-serving systems is considered collateral contact and may be necessary to meet their goals of the individual but is not billable through Medicaid. Services may be provided by these child-serving systems, however, the services provided must be funded through the agency providing the service.

3. Time spent in travel, transporting children, documenting, supervision, training, etc. has been factored into the indirect unit cost and may not be billed directly;
4. Medicaid funding may not reimburse for children in the custody of the Office of Juvenile Justice (OJJ), who reside in detention facilities, public institutions or secure care and are inmates of a public institution. If the child is in OJJ custody,

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but not in a public correctional institution (i.e., is outpatient), Medicaid will reimburse for the Homebuilders® except for the oversight of restorative measures, which is an OJJ function;

5. Medicaid will not reimburse for services provided to children who are residents of IMDs, which are institutions with greater than 16 beds, where more than 50 percent of the residents require treatment for BH conditions; and
6. Medicaid does not pay when the vocational supports provided via Homebuilders® qualify for vocational rehabilitation funding, even if the vocational rehabilitation services are not available.

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MULTI-SYSTEMIC THERAPY (MST)

MULTI-SYSTEMIC THERAPY

The provider agency must have a current license issued by MST Services® to provide Multi-Systemic Therapy (MST). The licensed entity has agreed to assume responsibility for this service under its license. The provider contracts with MST Services for training, supervision and monitoring of services. This occurs primarily through a MST national consultant. The provider will also have a contractual relationship with MST Services, allowing the provider to deliver the licensed MST model.

MST provides an intensive home/family and community-based treatment for youth who are at risk of out-of-home placement or who are returning from out-of-home placement. The MST model is based on empirical data and evidence-based interventions that target specific behaviors with individualized behavioral interventions. Services are primarily provided in the home, but workers also intervene at school and in other community settings. All MST services must be provided to, or directed exclusively toward, the treatment of the Medicaid-eligible youth.

Target Population Characteristics

MST services are targeted for youth primarily demonstrating externalizing behaviors, such as conduct disorder, antisocial or illegal behavior or acts that lead to costly and, oftentimes, ineffective out-of-home services or excessive use of child-focused therapeutic support services. Depression and other disorders are considered, as long as the existing mental and behavioral health (BH) issues manifest in outward behaviors that impact multiple systems (i.e., family, school, community). Youth with substance use issues may be included if they meet the criteria below, and MST is deemed clinically more appropriate than focused drug and alcohol treatment:

1. Referral/target ages of 12-17 years;
2. Exhibits significant externalizing behavior, such as chronic or violent juvenile offenses;
3. Is at risk for out-of-home placement or is transitioning back from an out-of-home setting;
4. Externalizing behaviors symptomatology, resulting in a DSM-5 diagnosis of conduct disorder or other diagnoses consistent with such symptomatology (oppositional defiant disorder, other disruptive, impulse-control, and conduct disorders, etc.);

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5. Ongoing multiple system involvement due to high risk behaviors and/or risk of failure in mainstream school settings due to behavioral problems;
6. Less intensive treatment has been ineffective or is inappropriate; or
7. Treatment planning team or Child Family Team (CFT) recommends that they participate in MST.

MST services may not be clinically appropriate for youth who meet the following conditions:

1. Referred primarily due to concerns related to suicidal, homicidal or psychotic behavior;
2. Living independently, or youth whom a primary caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends or other potential surrogate caregivers;
3. The referral problem is limited to sexual offending in the absence of other delinquent or antisocial behavior;
4. Have moderate to severe difficulties with social communication, social interaction, and repetitive behaviors, which may be captured by a diagnosis of autism;
5. Low-level need cases; or
6. Have previously received MST services or other intensive family- and community-based treatment.

Exception

Youth may be allowed an additional course of treatment if all of the following criteria are met:

1. MST program eligibility criteria are currently met;
2. Specific conditions have been identified that have changed in the youth’s ecology, compared to the first course of treatment;
3. It is reasonably expected that successful outcomes could be obtained with a second course of treatment; and

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APPENDIX E-4: EVIDENCED BASED PRACTICES (EBPs) POLICY –

MULTI-SYSTEMIC THERAPY (MST)

4. Program entrance is subject to prior authorization by the managed care organization (MCO).

Criteria for Continuing Services

Youth receiving MST services must meet all of the following criteria for continuing treatment with MST:

1. Treatment does not require more intensive level of care;
2. The treatment plan has been developed, implemented and updated based on the youth’s clinical condition and response to treatment, as well as the strengths of the family, with realistic goals and objectives clearly stated;
3. Progress is clearly evident in objective terms, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address the lack of progress are evident; and
4. The family is actively involved in treatment, or there are active, persistent efforts being made which are expected to lead to engagement in treatment.

Criteria for Discharge from Services

Youth who meet the following criteria no longer meet medical necessity criteria for MST and shall be discharged from MST treatment:

1. Treatment plan goals or objectives have been substantially met;
2. Meets criteria for a higher or lower level of treatment, care or services;
3. Family, guardian, and/or custodian are not engaging in treatment or not following program rules and regulations, despite attempts to address barriers to treatment; and
4. Consent for treatment has been withdrawn, or youth and/or family have not benefitted from MST, despite documented efforts to engage, and there is no reasonable expectation of progress at this level of care, despite treatment.

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APPENDIX E-4: EVIDENCED BASED PRACTICES (EBPs) POLICY –**MULTI-SYSTEMIC THERAPY (MST)**

Covered Services

Philosophy and Treatment Approach

The MST approach views individuals as being surrounded by a natural network of interconnected systems that encompass individual, family and extra-familial (peer, school and neighborhood) factors. The MST approach believes that it is often necessary to intervene in a number of these systems to achieve positive results. All interventions implemented during treatment come from evidenced-based treatment approaches. Through a combination of direct service contacts and collateral contacts, significant improvement in family functioning occurs, thereby reducing the need for continued professional services.

MST is based on the philosophy that the most effective and ethical way to help youth is by helping their families. MST views caregivers as valuable resources, even when they have serious and multiple needs of their own. One goal of MST is to empower caregivers to effectively parent their children. MST treatment reaches across all of the youth's life domains and is highly individualized around each case, as described below.

MST treatment principles include the following:

1. The primary purpose of assessment is to understand the fit between the identified problems and their broader systemic context;
2. Therapeutic contacts emphasize the positive and use systemic strengths as levers for change;
3. Interventions are designed to promote responsible behavior and decrease irresponsible behavior among family members;
4. Interventions are present-focused and action-oriented, targeting specific and well-defined problems;
5. Interventions target sequences of behavior within and between multiple systems that maintain the identified problems;
6. Interventions are developmentally appropriate and fit the developmental needs of the youth;
7. Interventions are designed to require daily or weekly efforts by family members;

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8. Intervention effectiveness is evaluated continuously from multiple perspectives, with the provider assuming accountability for overcoming barriers to successful outcomes; and
9. Interventions should be designed to promote treatment generalization and long-term maintenance of therapeutic change by empowering caregivers to address family members' needs across multiple systemic contexts.

These nine principles guide treatment and the development of interventions to address referral behaviors. The treatment theory draws from social-ecological and family systems theories of behavior. Staff supervision and consultation are focused on facilitating use of the MST model. A variety of measures are in place to monitor a program's adherence to the MST model and ensure that fidelity to the model is maintained to the greatest extent possible, as described below.

Goals

MST is designed to accomplish the following:

1. Reduce the frequency of referral behaviors and increase pro-social behaviors, reduce symptoms, maladaptive and externalizing behaviors, so that the child/youth can be treated in a lower level of community-based care. Child/youth no longer demonstrating ongoing risk of deliberate attempts to inflict serious injury on self or others;
2. Decrease association with deviant peers and increase association with pro-social peers and involvement in positive recreational activities;
3. Help caregivers develop effective parenting skills and skills to manage the consumer's mental health needs, improve caregiver decision-making and limit setting;
4. Improve family relationships;
5. Improve school or vocational success, as indicated by improved grade point average, a decrease in disciplinary referrals, unexcused absences and tardiness and/or a decrease in job terminations;
6. Support involvement in restorative measures, such as community services, if involved with Juvenile Justice (Office of Children, Youth and Families resources

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MULTI-SYSTEMIC THERAPY (MST)

will oversee and fund the participation in restorative measures, rather than the MST service provider);

7. Reduce likelihood of out-of-home placement and reduce the utilization of out-of-home therapeutic resources (i.e., therapeutic foster care, residential treatment facility, etc.); and
8. Develop natural supports for the consumer and family.

Specific treatment goals will always be individualized and tied to behavioral health needs.

Specific Design of the Service

On average, a youth receives MST for three to five months, but typically, no longer than five months. The therapist meets with the youth or family at least weekly but often multiple times per week, depending on need. Families typically see therapists less frequently as they get closer to discharge. On average, families receive about 60 hours of face-to-face treatment over a four-month period, as well as about 35 hours of non-direct contact provided to the ecology of the youth (e.g., consultation and collaboration with other systems). (Please note that these contact hours reflect averages only, and are not intended to specify a set number of family or member contacts. The MST model is intended to be a highly individualized treatment that is intensive and is delivered as frequently as is required to produce the outcomes desired for each specific youth). Services occur in the family’s home or community at times that are convenient for the family. Staff members are expected to work on weekends and evenings, for the convenience of their members. Therapists and/or their supervisors are on call for families 24/7. Supervisors are available to therapists around-the-clock for support. Each therapist carries a small caseload (four to six families) at any one time.

MST includes the following:

1. Assessment;
2. Ongoing treatment planning;
3. Family therapy;
4. Parent counseling (related to empowering caregivers to parent effectively and address issues that pose barriers to treatment goals);

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5. Consultation to and collaboration with other systems, such as school, juvenile probation, children and youth and job supervisors;
6. Individual therapy may occur but is not the primary mode of treatment; and
7. Referral for psychological assessment, psychiatric evaluation and medication management, if needed.

NOTE: The term “counseling” throughout the MST section is in keeping with the nomenclature of this evidenced based practice and should not be mistaken for the counseling and psychotherapy rendered by licensed mental health professionals (LMHPs) under their respective scope of practice license.

Unless it directly impacts the youth’s treatment, MST therapists do not provide individual therapy to caregivers or other family members, or marital therapy.

MST is a practical and goal-oriented treatment that specifically targets the factors in a youth’s social network that are contributing to the problem behaviors. Specific treatment techniques draw from therapies with the most empirical support, such as cognitive, cognitive behavioral, behavioral and pragmatic family therapies, such as structural family therapy. Interventions are developed based on an assessment of the “fit” for a specific behavior (specifically, what factors are driving the behavior, which are always individualized). Interventions always target specific, well-defined problems, focus on present conditions and are action-oriented. Families are often given “assignments” that require daily or weekly efforts, capitalize on strengths, build skills and encourage responsible behavior by the youth and family. By empowering caregivers to address their families’ needs, MST interventions promote generalization and maintenance of positive changes. The help of natural supports, such as extended family or school, is often enlisted.

Therapists are totally responsible for engaging the family and other key participants in the youth’s environment (e.g., teachers, school administrators, community members, workers from agencies with mandated involvement). MST requires a solution-focused, strengths-based orientation from therapists.

The effectiveness of interventions is closely monitored from each week, from multiple perspectives (e.g., caregivers, identified youth, teachers and the MST team). While overarching goals are established at the beginning of treatment, specific, measurable objectives are set each week. Family members and therapists work together to design the treatment plan, which ensures family involvement; however, therapists and the provider agency are held accountable for achieving change and for positive case outcomes.

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NOTE: The MST program has a hands-off policy and does not utilize any restraints or restrictive procedures.

Description of Individualization for Youth and Family

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 is developed by the MST therapist, based on the assessment, youth and family strengths, referral behaviors, and the goals of the youth and family. Goals of the youth, family, and other key participants in treatment (e.g., 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 is 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. Weekly Case Summaries are driven by continuous assessment, data collection and analysis, team and supervisory input, goal development, intervention development and implementation, outcome assessment, and ongoing plan revision.

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:

1. Develops Intermediary Goals that are specific, measureable action-oriented, realistic, and time-limited objectives;
2. Outlines intervention steps that will be taken to accomplish each Intermediary Goal;
3. Reviews previous Intermediary Goals; and

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4. 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.

Cultural Concerns

MST treatment is attuned to the importance of ethnicity and culture for all members referred for services. Cultural values and concerns shall be reflected in the MST therapist’s assessment of the youth and family and incorporated into interventions, as appropriate. Weekly clinical supervision shall include responsiveness to problems related to racism or discrimination. Cultural competence may be addressed in MST booster trainings if it is identified as an area of need by the MST supervisor and system supervisor.

Child Integration to Community

The treatment objectives must demonstrate that MST focuses on community integration by striving to reduce out-of-home placements, improve school attendance and academic success and build natural supports for the family.

By maintaining the youth within the community, the least restrictive environment, MST treatment interventions strengthen the family and youth’s relationship with community resources and the people managing them. This is important for creating sustainable treatment outcomes. Also, the MST model is strengths-focused and competency-based in its treatment approach. The general goal of MST is to promote increased emotional and social health in youth and families.

Provider Qualifications and Responsibilities

Agencies must be licensed to provide MST services by MST Services, Inc. or any of its approved subsidiaries. An MST agency must be a BH/substance use provider organization, which is a legally recognized entity in the United States and is qualified to do business in Louisiana and meets the standards established by the Bureau of Health Services Financing (BHSF) or its designee. MST agencies must be licensed pursuant to La. R.S. 40:2151, et. seq. for behavioral health service providers. The provider agency must meet all qualifications as required for other outpatient and rehabilitation agencies and must maintain documentation and verification of

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licensure, certification by MST Services, Inc., staff criminal background checks, tuberculosis (TB) testing, drug testing and required training for staff employed or contracted with the agency. MST-only agencies are not required to be accredited due to the extensive nature of consultation by MST Services, Inc. These agencies must maintain good standing with MST Services, Inc., ensure fidelity to the MST model and maintain licensure through the Louisiana Department of Health (LDH).

NOTE: Agencies providing non-Evidence Based Practice (EBP) rehabilitation and/or addiction services in addition to MST must be accredited by an LDH approved national accrediting body: Commission on Accreditation of Rehabilitation Facilities (CARF), Council on Accreditation (COA), or The Joint Commission (TJC).

The provider will provide all member services. MST therapists and supervisors are employees of the provider. Ultimate responsibility for services provided lies with the provider. The provider contracts with a network partner for training, supervision and monitoring of services. This occurs primarily through an MST system supervisor provided by the network partner. Network partner status, granted to the network partner’s MST program by MST Services, allows for the development of MST teams supported and monitored directly by the network partner. The provider also has a contractual relationship with MST Services, allowing the provider to deliver the licensed MST model.

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. Behavioral Health Service Providers (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.

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2. BHSPs **exclusively** providing the evidence-based practice Functional Family Therapy (FFT/FFT-CW), 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 requirements detailed in this manual chapter under *Provider Responsibilities* in Section 2.3 – Outpatient Services – Rehabilitation Services for Children, Adolescents, and Adults.

Allowed Provider Types and Specialties

PT 12 Multi-Systemic Therapy Agency, PS 5M Multi-Systemic Therapy.

Staff Education Level/Qualifications and Training Topics**Education/Qualifications**

The MST program at the provider consists of one or more MST teams, each with an MST clinical supervisor and two to four MST therapists. There is a system supervisor from the network partner, who is responsible for the clinical fidelity of the MST team. All staff will have background checks, TB testing, screenings and required training on file before working with youth and families.

MST Clinical Supervisor

The supervisor for an MST team is an independently licensed master's-level mental health professional with a graduate degree in a clinical mental health field and experience providing mental health treatment. A minimum of three years of experience is preferred. The supervisor facilitates weekly team supervision, reviews weekly case summaries in preparation for supervision and is available to therapists 24/7. The MST supervisor will, at times, take therapy cases, if needed, due to demand and staff availability. A full-time supervisor may supervise up to two teams; a half-time supervisor may supervise one team. Clinical services and supervision must be provided by LMHPs in accordance with their respective licensing board regulations. All practitioners must hold an unrestricted Louisiana license.

MST Therapist

Therapists are master's-level mental health professionals with graduate degrees in a clinical field, a background in family, youth and community service and a minimum of two years of experience is preferred. Highly skilled bachelor's-level professionals may be selected, with certain hiring conditions. These conditions include: (1) education in a human services field; (2) a minimum of three years' experience working with family and/or children/youth services; and (3) the provider has actively recruited for master's-level therapists but has not found any acceptable candidates or

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the bachelor's-level applicant is clearly better qualified than the master's-level applicants. Bachelor's level staff must have a degree in social work, counseling, psychology or a related human services field and must have at least three years of experience working with the target population (children/adolescents and their families). Therapists are responsible for providing direct service to a caseload of four to six families. The expectation is that the usage of bachelor's-level staff will not exceed one bachelor's-level staff person for every two master's-level staff persons per team.

NOTE: The term “therapist” is in keeping with the nomenclature of this evidenced based practice and should not be mistaken for LMHPs, who provide counseling and psychotherapy under their respective scope of practice license.

MST System Supervisor (MST consultant from the network partner)

The system supervisor is a master's-level, mental health professional with a graduate degree in a clinical field and experience as an MST clinical supervisor. The system supervisor provides weekly clinical consultation to the MST teams, monthly clinical consultation to the MST supervisors, quarterly booster trainings for the MST teams and monitors adherence to the MST model. A manager of network partnerships from MST Services is assigned to the network partner to monitor and train system supervisors.

Training

System supervisors are responsible for the training of MST therapists and MST clinical supervisors. All therapists and supervisors attend a 30-hour (five-day) MST orientation training within two months of hire. This training covers such topics as: engagement and alignment, parent-child interventions, marital interventions, school-based interventions, confidentiality and ethics, peer interventions, social supports, individual interventions, safety issues, substance use interventions and psychiatric consultation. All participants take a test at the end of the training week. Individual results of the tests are used to identify areas of strength and weakness for continued clinical development.

Booster trainings are conducted for one and a half days each quarter. The entire MST team attends a full day of booster training (minimum seven hours), while the half-day (minimum three and a half hours) may be attended by the entire team or only the supervisors. Topics for booster trainings are derived from planning discussions between the system supervisor and MST clinical supervisors as they reflect on challenges over the previous months. Examples of booster trainings include family contracting, interventions for families affected by divorce, safety planning, preventing burnout, caregiver substance use and school-based assessment and intervention. Orientation and booster trainings are led by MST-licensed system supervisors.

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Supervision

Intensive supervision and clinical consultation are an integral part of the MST model and are focused on promoting consistent application of the MST model to all cases. Training is monitored through the licensing agreements and contractual arrangement that the provider has with the network partner, and they with MST Services.

Supervision and consultation in MST includes the following:

1. MST therapists receive weekly team supervision with their MST supervisor, typically lasting one or two hours. If an MST supervisor has two teams, supervision is provided separately to each team. Prior to supervision meetings, the supervisor reviews weekly case summaries, makes notes and creates an agenda for the supervision meeting;
2. Each MST team receives weekly telephone consultation from an MST system supervisor, typically for one hour. Each week the system supervisor reviews case summaries and MST clinical supervisor notes, in preparation for the consultation session;
3. Each MST therapist has a clinical plan (professional development plan) to guide them to effective levels of MST adherence;
4. MST clinical supervisors are available around-the-clock to provide support to MST therapists; and
5. The MST clinical supervisors receive monthly telephone consultation from the system supervisor to monitor and develop their supervisory effectiveness. This supervision involves close review of audiotapes of supervision sessions and case reviews.

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.

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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.

Monitoring and Assessment of Service Delivery: The licensing agreement and contracts between MST Services, the network partner and the provider include monitoring activities to ensure fidelity to the MST model, as described below. Adherence to the model is monitored through the administration of two measures:

Therapist Adherence Measure-Revised (TAM-R): This is an objective, standardized instrument that evaluates a therapist's adherence to the MST model as reported by the primary caregiver of the family. It has been shown to have significant value in measuring a MST therapist's adherence to MST principles and to predicting treatment outcomes. The TAM-R has been validated in clinical trials with serious chronic, juvenile offenders and is now implemented by all licensed MST programs. The TAM-R takes 10 to 15 minutes to complete. It is administered during the second week of treatment and every four weeks thereafter. A staff person will contact the family in-person or by phone to complete the measure. Data is entered onto an online database managed by the MST Institute, and results are reviewed by the MST supervisor and therapist.

Supervisor Adherence Measure (SAM): This measure evaluates the MST clinical supervisor's adherence to the MST model of supervision. This 10 to 15-minute measure is completed by MST therapists, who are prompted to complete the SAM every two months and enter their responses directly onto the on-line database. Results are shared with the MST system supervisor, who then shares a summary of the feedback with the MST clinical supervisor during a consultation meeting.

The online database also collects case-specific information, including the percent of cases successfully completing MST and whether specific instrumental and ultimate outcomes have been achieved at discharge. The provider will ensure that the MST program collects TAM-R and SAM, as required by the model, and that this and other data is entered into the online database in a timely fashion.

Every six months, a program implementation review is completed by the system supervisor and MST clinical supervisor for each team. This review includes completion of a program review form (a checklist of characteristics considered critical to the success of an MST program), a narrative summary of the program's strengths and weaknesses and recommendations. This review is used to monitor the team's fidelity to the model and troubleshoot problem areas.

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Exclusions

MST services are comprehensive of all other services, with the exception of psychological evaluation or assessment, medication management, and Coordinated System of Care (CSoC) waiver services. These services may be provided and billed separately for a member receiving MST services.

MST shall not be billed in conjunction with the following services:

1. BH services by licensed and unlicensed individuals, with the exception of medication management, assessment, and CSoC waiver services; and/or
2. Residential services, including professional resource family care.

Medicaid will not reimburse for services provided to children who are residents of institutions for mental diseases (IMDs). These are institutions with greater than 16 beds, where more than 50 percent of the residents require treatment for BH conditions.

Billing

1. Only direct staff face-to-face time with the child or family may be billed. MST may be billed under community psychiatric supportive treatment (CPST), but must be consistent with the CPST Medicaid State Plan definition. CPST is a face-to-face intervention with the individual present; however, family or other collaterals may also be involved, and the child/youth receiving treatment does not need to be present for all contacts;
2. Collateral contacts billable to Medicaid shall involve contacts with parents, guardians or other individuals having a primary care relationship with the individual receiving treatment. All contacts must be based on goals from the child's/youth's plan of care. Phone contacts are not billable;

NOTE: The exception to the allowance of collateral contacts while providing evidence-based practices is coordination with other child-serving systems such as parole and probation programs, public guardianship programs, special education programs, child welfare/child protective services and foster care programs. Coordination with these child-serving systems is considered collateral contact and may be necessary to meet their goals of the individual, but is not billable through Medicaid. Services may be provided by these child-serving systems, however, the services provided must be funded through the agency providing the service.

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3. Time spent in travel, transporting children, documenting, supervision, training, etc. has been factored into the indirect unit cost and may not be billed directly;
4. Medicaid may not reimburse for children in the custody of the Office of Juvenile Justice (OJJ) who reside in detention facilities, public institutions or secure care, and are inmates of a public institution. If the child is in OJJ custody, but not in a public correctional institution (i.e., is outpatient), Medicaid will reimburse for the MST, except for the oversight of restorative measures, which is an OJJ function; and
5. Medicaid does not pay when the vocational supports provided via MST qualify for vocational rehabilitation funding, even if the vocational rehabilitation services are not available.

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CHILD PARENT PSYCHOTHERAPY

Child Parent Psychotherapy (CPP) is an intervention for children age 0-6 and their parents who have experienced at least one form of trauma including but not limited to maltreatment, sudden traumatic death of someone close, a serious accident, sexual abuse, or exposure to domestic violence. The primary goal of the treatment is to support and strengthen the relationship between a child and their parent (or caregiver) in order to repair the child's sense of safety, attachment, and appropriate affect to ultimately improve the child's cognitive, behavioral, and social functioning.

Child Parent Psychotherapy is a model used within the service Outpatient Therapy by Licensed Practitioners, so follows the requirements set out in the “Outpatient Therapy by Licensed Practitioners” section of this manual.

Evaluation of the Evidence Base for the EBP Model

Evaluation of the evidence-base for the CPP model has been conducted by a national registry.

CPP has received a CEBC Scientific Rating of 2-Supported by Research Evidence by the California Evidence Based Clearinghouse:

<http://www.cebc4cw.org/program/child-parent-psychotherapy/detailed>

The model and research evidence for CPP are also described in a fact sheet from The National Child Traumatic Stress Network (NCTSN):

https://www.nctsn.org/sites/default/files/interventions/cpp_fact_sheet.pdf

Target Population Characteristics

Children: Birth–6 years old that have:

1. Experienced at least one traumatic event; and
2. Are experiencing behavior, attachment, and/or mental health problems, including posttraumatic stress disorder (PTSD) because of experienced trauma.

Parent(s)/Caretaker(s) of traumatized child.

CPP may help when:

1. Children have been through scary or painful events such as:

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- a. Loss of a loved person;
 - b. Separation;
 - c. Serious medical procedures; and
 - d. Abuse or violence at home or in the community.
2. Children show difficult behaviors;
 3. Children have a change in placement or caregivers;
 4. Family members have physical health or mental health difficulties; or
 5. Caregivers would like help with parenting and improving parent-child relationships.

Philosophy and Treatment Approach

CPP is a dyadic treatment with both the parent/caregiver and child, because caregivers are the most important people in their children's lives. Parents/caregivers know their children best and are central to their development. Stressful experiences affect the parent-child relationship, and young children rely on their parents/caregivers to feel safe. When difficult things happen, young children need parents and caregivers to help them with the following:

1. Make sense of what their family went through;
2. Know what they can expect in the future; and
3. Learn to cope with challenging negative emotions.

Goals

1. Reduction in child PTSD symptoms;
2. Reduction in child behavior problems;
3. Increased child/parent attachment security; and

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4. Reduction in parent PTSD and other mental health symptoms.

Specific Design of the Service

Recommended Intensity:

Weekly 1 to 1.5-hour sessions.

Recommended Duration:

52 weeks (one year).

Delivery Settings

In order to follow the child, this program is typically conducted in a(n):

1. Adoptive Home;
2. Birth Family Home;
3. Community Agency;
4. Foster/Kinship Care;
5. Outpatient Clinic; and/or
6. School.

The type of trauma and the child’s age/developmental status determine the structure of CPP sessions. For example, if the child is an infant, the focus is on helping the parent(s) understand the trauma’s potential impact on development and/or functionality of the infant. Older children often take an active role in the treatment, which often involves play to facilitate communication between child and parent.

Cultural Considerations

According to a review by The National Child Traumatic Stress Network (NCTSN), the model is broadly tailored and the basic theoretical principles and core goals of CPP are thought to apply

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across diverse groups. The treatment has been used extensively with a wide range of minority groups: Latino (Mexican, Central, and South American), African-American, and Asian (Chinese). Clinical and research data, including four randomized trials conducted with predominantly ethnic minority samples, document the efficacy of this approach with culturally diverse groups.

Additional culture-specific information on CPP can be found in a NCTSN fact sheet at: https://www.nctsn.org/sites/default/files/interventions/cpp_culture_specific_fact_sheet.pdf

Provider Qualifications and Responsibilities

EBP Model Requirements

Therapists must achieve satisfactory completion of the full 18 month CPP training, upon which the clinician will be eligible to join the roster of nationally trained CPP therapists. This list is held by the Child Parent Psychotherapy Learning Collaborative in Louisiana. Providers must submit verification of inclusion on the roster of nationally trained CPP therapists to each MCO with whom it contracts to demonstrate eligibility for CPP therapist status. Verification must be maintained in the therapist’s personnel folder.

All clinicians seeking to complete training and be eligible for the CPP roster must be masters or doctoral-level licensed psychotherapists with a degree in a mental health discipline.

Certification should be maintained by engaging in periodic fidelity review activities, including completion of a CPP Case Presentation (template) and case consultation calls with a CPP Trainer, at the frequency described below in the description of fidelity monitoring.

Other Qualifications and Requirements

Practitioners must meet qualifications and requirements established in the Outpatient Therapy by Licensed Practitioners section of this manual.

Allowed Provider Types and Specialties

1. PT 31 Psychologist PS:
 - a. 6A Psychologist – Clinical;
 - b. 6B Psychologist – Counseling;

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- c. 6C Psychologist – School;
 - d. 6D Psychologist – Developmental;
 - e. 6E Psychologist - Non-declared;
 - f. 6F Psychologist – Other; and
 - g. 6G Psychologist – Medical.
2. PT 73 Social Worker (Licensed/Clinical) PS:
- a. 73 Licensed Clinical Social Worker (LCSW); and
 - b. LL Lower Level – Licensed Master Social Worker (LMSW).
3. PT AK Licensed Professional Counselor (LPC) PS:
- a. 8E CSoC/Behavioral Health – LPC; and
 - b. LL Lower Level – Provisionally Licensed Professional Counselor (PLCP).
4. PT AH Licensed Marriage & Family Therapists (LMFT) PS:
- a. 8E CSoC/Behavioral Health – LMFT; and
 - b. LL Lower Level – Provisionally Licensed Marriage and Family Therapist (PLMFT).
5. PT AJ Licensed Addiction Counselor PS 8E CSoC/Behavioral Health;
6. PT 20 Psychiatrist PS;
- a. 26 Psychiatry; and
 - b. 2W Addiction Specialist.

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7. PT 78 Advanced Practice Registered Nurse PS 26;
8. PT 93 Clinical Nurse Specialist PS 26; and
9. PT 94 Physician Assistant PS 26.

Training

The intensive 18-month training structure includes:

1. 3 day - initial core didactics is \geq 18 hours face to face classroom time;
2. 6 months- twice-monthly consultation calls for treatment collaboration;
3. 2 day – face-to-face participant driven case based collaboration between training clinicians and trainer;
4. 6 months –twice-monthly consultation calls to strengthen and support development;
5. 2 days – face-to-face competence building with case based participant driven collaboration lead by the trainer; and
6. 6 months – continued consultation and supportive twice-monthly calls.

Minimum requirements include:

1. Therapist must attend all face-to-face sessions and a minimum of 70% of the consultation calls during the 18-month period; and
2. Therapists must work with at least four (4) qualifying parent-child dyads in the 18-month period.

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Quality Assurance

Outcomes

Outcomes to be measured in the delivery of CPP include:

1. Effectiveness of CPP on reducing behavioral symptoms among CPP members as evidenced by the (ECSA) Brief Early Childhood Screening Assessment once before treatment, at the 6 month interval, and again post treatment as reported by the guardian; and
2. Effectiveness of CPP on improving caregiver/child relationship as measured using The Relationship Scale at pre- and post- treatment.

Model-Specific Documentation Requirements

Case Consultation form. While not completed on every case as required practice, the Case Consultation form is a tool that should be completed on specific cases that will be submitted for fidelity review.

Fidelity

Therapist fidelity to the CPP model is monitored via therapist submission of a Case Consultation form for one case, at two different time points during the case (early in treatment, as well as 2-3 months into treatment).

These Case Consultation forms are submitted to the CPP Trainer, who will review and follow up with the therapist on a 30-60 minute case consultation phone call.

To maintain CPP fidelity, CPP therapists should submit Case Consultation forms and complete a case consultation call with a CPP trainer at the following frequency:

1. For the first 2 years post-certification: Every 6 months; and
2. Beyond 2 years post-certification: Annually.

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CPP, as a service offered under Outpatient Therapy by Licensed Practitioners, has an initial authorization level of benefit, and services which exceed the limitation of the initial authorization may require approval for re-authorization prior to service delivery. The recommended duration of the CPP model is 52 weeks; therefore re-authorization should be requested indicating that the specialty model CPP is being utilized and therefore appropriately may exceed the initial authorization and should be authorized for continuing services to complete the medically necessary treatment episode and provide evidence-based care to the youth and family.

Billing

1. Only direct staff face-to-face time with the child or family may be billed. CPP is a face-to-face intervention with the individual and caregiver present; however, the child receiving treatment does not need to be present for all contacts. If the child is not present, the appropriate procedure code must be billed, e.g. 90846 - Family Psychotherapy without Patient Present;
2. Collateral contacts billable to Medicaid should involve contacts with parents/guardians using the appropriate procedure code as stated above. All contacts must be based on goals from the child's/youth's plan of care. Phone contacts are not billable;

NOTE: The exception to the allowance of collateral contacts while providing evidence-based practices is coordination with other child-serving systems such as parole and probation programs, public guardianship programs, special education programs, child welfare/child protective services and foster care programs. Coordination with these child-serving systems is considered collateral contact and may be necessary to meet their goals of the individual, but is not billable through Medicaid. Services may be provided by these child-serving systems, however, the services provided must be funded through the agency providing the service.

3. Therapists bill standard CPT individual and family therapy codes for sessions providing CPP. The EB tracking code "EB02" should be indicated on claims to note that the therapy session utilized CPP as an evidence-based model of therapeutic intervention;
4. To use the CPP EB tracking code of "EB02" on claims, the therapist must first provide documentation (stating that the clinician has fulfilled the requirements of an implementation level course in Child-Parent Psychotherapy from a trainer

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CHILD PARENT PSYCHOTHERAPY

endorsed by the University of California, San Francisco) to the MCO(s) the provider is contracted with as part of the therapist's credentialing; and

5. LMSWs, PLPCs and PLMFTs may not directly bill for services provided to a Medicaid enrollee. LMSWs, PLPCs and PLMFTs may be the rendering provider on a claim when in accordance with Title 46 and their individual practice acts.

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PARENT CHILD INTERACTION THERAPY

Parent-child interaction therapy (PCIT) is an evidence-based behavior parent training treatment developed by Sheila Eyberg, PhD for young children with emotional and behavioral disorders that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns. Children and their caregivers are seen together in PCIT. Parents are taught and practice communication skills and behavior management with their children in a playroom while coached by therapists. The activities and coaching by a therapist enhance the relationship between parent and child and help parents implement non-coercive discipline strategies.

PCIT is a model used within the service Outpatient Therapy by Licensed Practitioners, so follows the requirements set out in the “Outpatient Therapy by Licensed Practitioners” section of this manual.

Evaluation of the Evidence Base for the EBP Model

Evaluation of the evidence-base for the PCIT model has been conducted by national registries.

Blueprints Programs lists PCIT as a Certified Promising Program:

<http://www.blueprintsprograms.com/programs>

PCIT has received a CEBC Scientific Rating of 1-Well Supported by Research Evidence by the California Evidence Based Clearinghouse:

<http://www.cebc4cw.org/program/parent-child-interaction-therapy/>

The model and research evidence for PCIT are also described in a fact sheet from The National Child Traumatic Stress Network (NCTSN):

https://www.nctsn.org/sites/default/files/interventions/pcit_fact_sheet.pdf

Target Population Characteristics

PCIT serves children ages 2-7 years old (can be up to 9 based on clinical judgement) with:

1. Disruptive behavior problems;
2. Attention-Deficit/Hyperactivity Disorder (ADHD);
3. Selective mutism; or
4. Anxiety.

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**APPENDIX E-6: EVIDENCED BASED PRACTICES (EBPs) POLICY –
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PCIT may not be clinically appropriate for individuals with significant social reciprocity deficits.

PCIT effectively serves children whose parents:

1. Have limited experience with children;
2. Have limited support;
3. Feel overwhelmed by their child’s behavior;
4. Feel angry at their child;
5. Have a child with an opposing temperament from their own; or
6. Feel their child is out of control.

Philosophy and Treatment Approach

PCIT is based on many of the same theoretical underpinnings as other parent training models. However, the treatment format differs from many other behavior parent training programs that take more of a didactic approach to working with families. Specifically, parents are initially taught relationship enhancement or discipline skills that they will practice in session and at home with their child.

In subsequent sessions, most of the session time is spent coaching caregivers in the application of specific therapy skills. Therapists typically coach from an observation room with a one-way mirror into the playroom, using a “bug-in-the-ear” system for communicating to the parents as they play with their child.

More recent advances in technology have allowed for coaching via video feed from another room which has reduced the need for adjoining clinical spaces. Concluding each session, the therapist and caregiver together decide which skills to focus on most during daily 5-minute home practice sessions the following week.

Goals

1. Improve parent/caregiver-child relationships;
2. Improve children’s cooperation;
3. Increase children’s abilities to manage frustration and anger;

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4. Increase children’s appropriate social skills;
5. Improve children’s attention skills;
6. Build children’s self-esteem;
7. Increase parenting skills; and
8. Decrease caregiver’s stress.

Specific Design of the Service

PCIT can be provided in a clinic or home-based setting, and is typically provided in weekly therapy sessions. A typical course of treatment may average 15-20 sessions. However, traditional PCIT differs from other parent training treatment strategies in that treatment is not session-limited. Specifically, families graduate from treatment when parents demonstrate mastery of skills and rate their child's behaviors as being within normal limits. The model duration depends on clinical outcome.

Specifically, the first portion (“child directed interaction”) is completed when a parent meets specific criteria defined as “mastery” of the skills of child directed intervention. The therapist first teaches the parent the Child Directed Interaction (CDI) skills in a didactic, parent-only session. Then in subsequent sessions, the therapist coaches the parent (through a “bug-in-the-ear” system”) in the parents’ use of those CDI skills during play with their child. CDI skills include the “PRIDE” skills: Praise, Reflect, Imitate, Describe, and Enjoy.

The second portion (“parent directed interaction”) similarly depends on parental successful achievement of specific mastery criteria. The therapist first teaches the parent the Parent Directed Interaction (PDI) skills in a didactic, parent-only session. Then in subsequent sessions, the therapist coaches the parent (through a “bug-in-the-ear” system”) in the parents’ use of those PDI skills during play with their child. PDI skills include effective commands, and compliance strategies, including predictable and consistent consequences such as time out and removal of privileges.

Cultural Considerations

As summarized in the Blueprints Programs Fact Sheet on PCIT, diverse samples have been included in evaluation studies, including heavy concentrations of both White and African

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American children and families. One study included Puerto Rican families. Cross-national generality has been demonstrated in a Chinese sample.

According to a review by The National Child Traumatic Stress Network (NCTSN), the PCIT model is broadly tailored and thought to apply across diverse groups. Researchers have also described specific adaptations of PCIT with Mexican American families, and with Native American families. PCIT does not pathologize normal cultural variations or impose a single standard of parenting and child behavior on clients. Cultural variations in tolerance for “disruptive” behavior in children are addressed in Dr. Eyberg’s teaching by asking parents during live coaching if a particular child behavior is something they want to see reduced through strategic ignoring.

Additional culture-specific information on PCIT can be found in a NCTSN fact sheet at: https://www.nctsn.org/sites/default/files/interventions/pcit_culture_specific_fact_sheet.pdf

Provider Qualifications and Responsibilities

EBP Model Requirements

The provider must be credentialed by PCIT International and have an active PCIT certification. PCIT certification must be renewed every two years through PCIT International. The recertification requires the therapist to have obtained at least 3 hours of PCIT Continuing Education credit the last 2 years through educational activities sponsored by the PCIT International Task Force on Continuing Education.

Providers must submit verification of active PCIT certification to each MCO with whom it contracts to demonstrate eligibility for PCIT therapist status. Verification must be maintained in the therapist’s personnel folder.

Other Qualifications and Requirements

Practitioners must meet qualifications and requirements established in the Outpatient Therapy by Licensed Practitioners section of this manual.

Allowed Provider Types and Specialties

1. PT 31 Psychologist PS:
 - a. 6A Psychologist – Clinical;
 - b. 6B Psychologist – Counseling;

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- c. 6C Psychologist – School;
 - d. 6D Psychologist – Developmental;
 - e. 6E Psychologist - Non-declared;
 - f. 6F Psychologist – Other; and
 - g. 6G Psychologist – Medical.
2. PT 73 Social Worker (Licensed/Clinical) PS:
- a. 73 Licensed Clinical Social Worker (LCSW); and
 - b. LL Lower Level – Licensed Master Social Worker (LMSW).
3. PT AK Licensed Professional Counselor (LPC) PS:
- a. 8E CSoC/Behavioral Health – LPC; and
 - b. LL Lower Level – Provisionally Licensed Professional Counselor (PLPC).
4. PT AH Licensed Marriage & Family Therapists (LMFT) PS:
- a. 8E CSoC/Behavioral Health – LMFT; and
 - b. LL Lower Level – Provisionally Licensed Marriage and Family Therapist (PLMFT).
5. PT AJ Licensed Addiction Counselor PS 8E CSoC/Behavioral Health;
7. PT 20 Psychiatrist PS:
- a. 26 Psychiatry; and
 - b. 2W Addiction Specialist.

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**APPENDIX E-6: EVIDENCED BASED PRACTICES (EBPs) POLICY –
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8. PT 78 Advanced Practice Registered Nurse PS 26;
9. PT 93 Clinical Nurse Specialist PS 26; and
10. PT 94 Physician Assistant PS 26.

Training

Basic Training. To apply for status as a Certified PCIT Therapist, an applicant must demonstrate appropriate Basic Training, as evidenced by the following:

1. 40-hours of face-to-face training with a PCIT Level II or Master Trainer that includes an overview of the theoretical foundations of PCIT, DPICS coding practice, case observations, and coaching with families, with a focus on mastery of CDI and PDI skills, and a review of the 2011 PCIT Protocol. The 40 hours of training may be conducted via didactic training, a mentorship model, or any combination of the two. PCIT training is ideally offered over a period of time rather than limited to one time point. For example, CDI training conducted at one time, followed by PDI training at a later date;
2. 10 hours of online training from a program endorsed by PCIT International and 30 hours of face-to-face contact with a PCIT Level II or Master Trainer. Online training must be supplemented with skills review from a PCIT Trainer. Therefore, the 30 hours of face-to-face training may be conducted in didactic training, a mentorship model, or any combination of the two. This training will include an overview of the theoretical foundations of PCIT, DPICS coding practice, case observations, and coaching with families, with a focus on mastery of CDI and PDI skills, and a review of the 2011 PCIT Protocol; or
3. 40 hours of PCIT training with a PCIT International Level 1 Trainer using a combination of didactic training and live co-therapy and supervision. Training from a PCIT Level 1 Trainer must include a minimum of 20 hours of co-therapy and/or live case supervision and continue until the trainee meets CDI and PDI coaching competencies. Video review or phone consultation cannot be used in lieu of the co-therapy or live-supervision requirements. This training will include an overview of the theoretical foundations of PCIT, DPICS coding practice, case observations, and coaching with families, with a focus on mastery of CDI and PDI skills, and a review of the 2011 PCIT Protocol.

Prior to PCIT certification, therapist trainees must complete two (2) cases under supervision with real time or video review of skills.

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**APPENDIX E-6: EVIDENCED BASED PRACTICES (EBPs) POLICY –
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The treatment model depends on measurement of the Eyberg Child Behavior Inventory (ECBI) regularly throughout the treatment (minimally baseline, every 3-4 sessions, and at completion) as well as coding parent skills using the Dyadic Parent Child Interaction Coding System (DPICS) at each visit. The ECBI has established levels of symptoms under which the likelihood of relapse is diminished. DPICS skills are tracked and guide treatment.

Model-Specific Documentation Requirements

All PCIT sessions should be conducted with fidelity according to the appropriate session outline found in the PCIT International protocol (see PCIT Integrity Checklists at the end of each session outline). Sessions should be guided by real-time data, including a weekly ECBI, reported homework completion, and skills coding. Progress should be shared with the family at the conclusion of each session, as well as documented in their chart, using an ECBI (Eyberg Child Behavior Inventory), and a Skills Summary Sheet.

Both the ECBI and Skills Summary Sheet should be updated weekly, and both kept in the client's chart.

Fidelity

In order to reach the standard to be a Certified PCIT Therapist (as per PCIT International) the therapist must serve as a therapist for a minimum of two PCIT cases to graduation criteria as defined by the 2011 PCIT Protocol. Until the two PCIT cases meet graduation criteria, the applicant must remain in contact via real-time consultation (e.g., telephone conference or live, online, or telehealth observation) or video review with feedback with a certified PCIT Trainer at least twice a month. The PCIT protocol (which the therapist receives consultation on throughout the course of the case) includes therapist completion of a fidelity checklist at each session, and review of fidelity during supervision.

Fidelity is then directly assessed via the following requirement: Applicants must have their treatment sessions observed by a certified PCIT Trainer. Observations may be conducted in real time (e.g., live or online/telehealth) or through video recording.

PCIT therapist certification requirements can be found here:

http://www.pcit.org/uploads/6/3/6/1/63612365/therapist_training_guidelines_revised_1.25.18_final.pdf

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PCIT does not require post-certification fidelity monitoring. PCIT does require re-certification every two (2) years, with evidence of PCIT Continuing Education hours.

Limitations/Exclusions

PCIT, as a service offered under Outpatient Therapy by Licensed Practitioners, has an initial authorization level of benefit, and services which exceed the limitation of the initial authorization may require approval for re-authorization prior to service delivery.

As per the PCIT model, families graduate from treatment when parents demonstrate mastery of skills and rate their child's behaviors as being within normal limits. PCIT sessions continue through completion of the “child directed interaction” component, and the “parent directed interaction” component, both of which are completed when a parent meets specific criteria defined as “mastery” of the skills. While a typical course of treatment averages 15-20 sessions, PCIT is not session-limited but instead the model duration depends on clinical outcome. Therefore, effective treatment duration may exceed the initial authorization level of benefit; in that case re-authorization should be requested indicating that the specialty model PCIT is being utilized and services appropriately may exceed the initial authorization and should be authorized for continuing services to complete the medically necessary treatment episode and provide evidence-based care to the youth and family.

Billing

1. Only direct staff face-to-face time with the child or family may be billed. PCIT is a face-to-face intervention with the individual and caregiver present; however, the child receiving treatment does not need to be present for all contacts. If the child is not present, the appropriate procedure code must be billed, e.g. 90846 - Family Psychotherapy without Patient Present;
2. Collateral contacts billable to Medicaid should involve contacts with parents, guardians using the appropriate procedure code as stated above. All contacts must be based on goals from the child's/youth's plan of care. Phone contacts are not billable;

NOTE: The exception to the allowance of collateral contacts while providing evidence-based practices is coordination with other child-serving systems such as parole and probation programs, public guardianship programs, special education programs, child welfare/child protective services and foster care programs. Coordination with these child-serving systems is considered collateral contact and may be necessary to meet their goals of the individual, but is not billable through Medicaid. Services may be provided by these child-serving systems, however, the services provided must be funded through the agency providing the service.

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3. Therapists bill standard CPT individual and family therapy codes for sessions providing PCIT. The EB tracking code “EB03” should be indicated on claims to note that the therapy session utilized PCIT as an evidence-based model of therapeutic intervention;
4. To use the PCIT EB tracking code of “EB03” on claims, the therapist must first provide documentation of their active certification from PCIT International to the MCO(s) the provider is contracted with, as part of the therapist’s credentialing; and
5. LMSWs, PLPCs and PLMFTs may not directly bill for services provided to a Medicaid enrollee. LMSWs, PLPCs and PLMFTs may be the rendering provider on a claim when in accordance with Title 46 and their individual practice acts.

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PRESCHOOL PTSD TREATMENT AND YOUTH PTSD TREATMENT**

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**PRESCHOOL Posttraumatic Stress Disorder (PTSD) TREATMENT AND
YOUTH PTSD TREATMENT**

Preschool PTSD Treatment (PPT) and **Youth PTSD Treatment (YPT)** are cognitive behavioral therapy interventions for posttraumatic stress disorder (PTSD) and trauma-related symptoms. PPT and YPT are adapted for different age groups:

1. Preschool PTSD Treatment (PPT) is used for children ages 3-6; and
2. Youth PTSD Treatment (YPT) is used for children and youth ages 7-18.

PPT and YPT are models used within the service Outpatient Therapy by Licensed Practitioners, so follows the requirements set out in the “Outpatient Therapy by Licensed Practitioners” section of this manual.

Evaluation of the Evidence Base for the EBP Model

Evaluation of the evidence-base for the PPT model has been conducted by national registries.

Preschool PTSD Treatment was accepted in 2012 in the National Registry of Evidence-Based Programs and Practices.

Preschool PTSD has received a CEBC Scientific Rating of 3-Promising Research Evidence by the California Evidence Based Clearinghouse: <http://www.cebc4cw.org/program/preschool-ptsd-treatment/>

Target Population Characteristics

PPT: Children ages 3-6 years old with posttraumatic stress symptoms.

YPT: Children and youth ages 7-18 years old with posttraumatic stress symptoms.

Philosophy and Treatment Approach

The essential components of PPT and YPT include:

1. Psychoeducation about posttraumatic stress disorder (PTSD) with pictorial aids;

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2. A focus on defiant behavior and discipline plans following trauma;
3. Identification of feelings and gradations of feelings in young children;
4. Relaxation exercises as new coping skills;
5. Narrative techniques for recall of traumatic events;
6. In-office and homework exposure exercises;
7. Development of developmentally appropriate safety plans;
8. Relapse prevention session;
9. Attunement of parents to children’s internalized phenomena through observation of sessions and reflection with therapist;
10. Involvement of caregivers in every aspect of treatment;
11. Direct discussion of reluctance to attend therapy; and
12. Time for caregivers to discuss their personal issues if appropriate.

PPT involves the family or other support systems in the individual's treatment. At least one primary caregiver is involved in every therapy session, either in the room with the therapist and the child, observing the child’s sessions on TV, or talking alone with the therapist. Caregivers are also essential for conducting in vivo (outside the office) exposure exercises as homework with the children.

YPT also involves the parents/caregivers. Three sessions - session 1 (psychoeducation), session 2 (oppositional defiant behavior), and session 12 (review) – are joint parent-child sessions. For the other nine sessions, parents will join the therapist and children at the beginning briefly (less than 5 minutes), and then watch the children’s sessions on a monitor. This is flexible and can be opted out of if the youth desires more privacy or the therapist believes the parent has boundary issues and would not respect the privacy of the youth.

Goals

The primary goal of PPT and YPT is the reduction of PTSD symptoms in children and reduction in functional impairment.

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Specific Design of the Service

Recommended Intensity:

One 60-minute session per week.

Recommended Duration:

12 sessions.

Delivery Setting:

This program is typically conducted in an outpatient clinic.

Cultural Considerations

The PPT and YPT models have not been tested for use in non-English speaking populations.

In a randomized controlled trial of PPT demonstrating significant improvement in PTSD symptoms, the participants were 59.5 percent Black/African American, 35.1 percent White, and 5.4 percent Other, but there was not sufficient power in the sample size to test for different outcomes by race.

Details may be found in the following publication:

Scheeringa MS, Weems CF, Cohen JA, Amaya-Jackson L, Guthrie D (2011). Trauma-focused cognitive-behavioral therapy for posttraumatic stress disorder in three through six year-old children: A randomized clinical trial. Journal of Child Psychology and Psychiatry, 52, 8, 853-860.

Provider Qualifications and Responsibilities

EBP Model Requirements

Therapists must receive training and consultation, as outlined below under “Training,” to receive “Advanced” certification in PPT or YPT from Tulane Psychiatry. All clinicians seeking to complete training and to be eligible for advanced certification in PPT or YPT must be masters or doctor-level licensed psychotherapists with a degree in a mental health discipline.

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Providers must submit verification of “Advanced” certification in PPT or YPT from Tulane Psychiatry to each MCO with whom it contracts to demonstrate eligibility for PPT or YPT therapist status. Verification must be maintained in the therapist’s personnel folder.

Other Qualifications and Requirements

Practitioners must meet qualifications and requirements established in the Outpatient Therapy by Licensed Practitioners section of this manual.

Allowed Provider Types and Specialties

1. PT 31 Psychologist PS:
 - a. 6A Psychologist – Clinical;
 - b. 6B Psychologist – Counseling;
 - c. 6C Psychologist – School;
 - d. 6D Psychologist – Developmental;
 - e. 6E Psychologist - Non-declared;
 - f. 6F Psychologist – Other; and
 - g. 6G Psychologist – Medical.

2. PT 73 Social Worker (Licensed/Clinical) PS:
 - a. 73 Licensed Clinical Master Social Worker (LCSW); and
 - b. LL Lower Level – Licensed Master Social Worker (LMSW).

3. PT AK Licensed Professional Counselor (LPC) PS:
 - a. 8E CSoc/Behavioral Health – LPC; and

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- b. LL Lower Level – Provisionally Licensed Professional Counselor (PLPC).
- 4. PT AH Licensed Marriage & Family Therapists (LMFT) PS:
 - a. 8E CSoC/Behavioral Health – LMFT; and
 - b. LL Lower Level – Provisionally Licensed Marriage and Family Therapist (PLMFT).
- 5. PT AJ Licensed Addiction Counselor PS 8E CSoC/Behavioral Health;
- 6. PT 20 Psychiatrist PS:
 - a. 26 Psychiatry; and
 - b. 2W Addiction Specialist.
- 7. PT 78 Advanced Practice Registered Nurse PS 26;
- 8. PT 93 Clinical Nurse Specialist PS 26; and
- 9. PT 94 Physician Assistant PS 26.

Training

Training is conducted through attendance at a one-day training workshop followed by six (6) months of weekly telephone consultation as trainees use the model on their own clients.

Tulane Psychiatry will issue an “Advanced” certificate in PPT or YPT following completion of the in-person training workshop and 6 months of subsequent consultation with the PPT or YPT trainer.

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Quality Assurance

Outcomes

In PPT, PTSD symptoms are measured with a parent-report questionnaire, the Young Child PTSD Checklist.

In YPT, PTSD symptoms are measured with a questionnaire, the Child PTSD Checklist (CPC). The CPC has both child-report and caregiver-report versions. This checklist should ideally be completed by both the youth and the caregiver; however, if that is not feasible due to age or logistics, one respondent is acceptable.

These checklists needs to be administered prior to treatment and immediately post-treatment to document change in symptom severity.

Model-Specific Documentation Requirements

Progress notes should be completed using the “Treatment Fidelity Progress Note” for PPT or YPT. There is a specific progress note format for each of the 12 sessions of PPT and YPT, requiring therapists to document completion of the core tasks for each treatment session.

Fidelity

Fidelity monitoring can be achieved by auditing the “Treatment Fidelity Progress Notes.” The audit would produce a passing score if 90 percent of the core tasks were partially or fully completed.

The EBP developer recommends that every six (6) months, a sample of completed cases should be identified, and the PPT or YPT therapist will submit for each selected (completed) case the full set of “Treatment Fidelity Progress Notes” for that case.

Limitations/Exclusions

PPT and YPT are not recommended for children and youth with autism or psychosis. As previously noted, PPT and YPT have not been adapted or tested for use with non-English speaking children and families.

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PPT and YPT, as a service offered under Outpatient Therapy by Licensed Practitioners, has an initial authorization level of benefit, and services which exceed the limitation of the initial authorization may require approval for re-authorization prior to service delivery.

The recommended duration of the PPT and YPT models is 12 sessions. If additional sessions are needed to complete PPT or YPT, re-authorization should be requested indicating that the specialty model PPT or YPT are being utilized and therefore appropriately may exceed the initial authorization and should be authorized for continuing services to complete the medically necessary treatment episode and provide evidence-based care to the youth and family.

Billing

1. Only direct staff face-to-face time with the child or family may be billed. PPT and YPT are face-to-face interventions with the individual present; however, the caregiver is also involved, and the child/youth receiving treatment does not need to be present for all contacts. If the child is not present, the appropriate procedure code must be billed, e.g. 90846 – Family Psychotherapy without Patient Present;
2. Collateral contacts billable to Medicaid should involve contacts with parents, guardians using the appropriate procedure code as stated above. All contacts must be based on goals from the child’s/youth’s plan of care. Phone contacts are not billable;

NOTE: The exception to the allowance of collateral contacts while providing evidence-based practices is coordination with other child-serving systems such as parole and probation programs, public guardianship programs, special education programs, child welfare/child protective services and foster care programs. Coordination with these child-serving systems is considered collateral contact and may be necessary to meet their goals of the individual, but is not billable through Medicaid. Services may be provided by these child-serving systems, however, the services provided must be funded through the agency providing the service.

3. Therapists bill standard CPT individual and family therapy codes for sessions providing PPT and YPT;
4. The EB tracking code “EB04” should be indicated on claims to note that the therapy session utilized YPT as an evidence-based model of therapeutic intervention;

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5. To use the YPT EB tracking code of “EB04” on claims, the therapist must first provide documentation of their Advanced Certification from Tulane Psychiatry to the MCO(s) the provider is contracted with, as part of the therapist’s credentialing package;
6. The EB tracking code “EB05” should be indicated on claims to note that the therapy session utilized PPT as an evidence-based model of therapeutic intervention;
7. To use the PPT EB tracking code of “EB05” on claims, the therapist must first provide documentation of their Advanced Certification from Tulane Psychiatry to the MCO(s) the provider is contracted with, as part of the therapist’s credentialing package; and
8. LMSWs, PLPCs and PLMFTs may not directly bill for services provided to a Medicaid enrollee. LMSWs, PLPCs and PLMFTs may be the rendering provider on a claim when in accordance with Title 46 and their individual practice acts.

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APPENDIX E-8: EVIDENCED BASED PRACTICES (EBPs) POLICY –

TRIPLE P- STANDARD LEVEL 4

TRIPLE P POSITIVE PARENTING PROGRAM – STANDARD LEVEL 4

The Triple P Positive Parenting Program is a parenting and family support system designed to prevent and treat behavioral and emotional problems in children. It aims to prevent problems in the family, school and community before they arise and to create family environments that encourage children to realize their potential. The “Triple P System” includes a suite of interventions with different intensity levels and delivery methods, to meet the individual needs of youth and parents.

Triple P – Standard Level 4 is designed to be delivered to the parents of children with moderate to severe behavioral difficulties. It is available for parents of children from birth to 12 years old and covers Triple P's 17 core positive parenting skills that can be adapted to a wide range of parenting situations.

Triple P – Standard Level 4 is a model used within the service “Outpatient Therapy by Licensed Practitioners.” Therefore, it follows the requirements set out in the “Outpatient Therapy by Licensed Practitioners” section of this manual.

Evaluation of the Evidence Base for the EBP Model

Evaluation of the evidence-base for the Triple P model has been conducted by national registries.

Triple P Level 4 has received a CEBC Scientific Rating of 1-Well Supported by Research Evidence by the California Evidence Based Clearinghouse:

<http://www.cebc4cw.org/program/triple-p-positive-parenting-program-level-4-level-4-triple-p/>

Blueprints Programs lists Triple P as a Promising Program:

<https://www.blueprintsprograms.org/programs/463999999/triple-p-system/print/>

Target Population Characteristics

The target population includes children ages 0-12 with their parents/primary caregivers. The program is used as an intervention with the parents of children with social, emotional, or behavioral problems. Triple P Standard Level 4 is recommended for children with diagnosed social, emotional, or behavioral concerns.

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APPENDIX E-8: EVIDENCED BASED PRACTICES (EBPs) POLICY –**TRIPLE P- STANDARD LEVEL 4**

Philosophy and Treatment Approach

Triple P draws on social learning, cognitive behavioral and developmental theories, as well as research into risk factors associated with the development of social and behavioral problems in children. It aims to equip parents with the skills and confidence they need to be self-sufficient and to be able to manage family issues without ongoing support.

Triple P - Standard Level 4 helps parents learn strategies that promote social competence and self-regulation in children and decreases problem behavior. Parents are encouraged to develop a parenting plan that makes use of a variety of Triple P - Standard Level 4 strategies and tools. Parents are then asked to practice their parenting plan with their children.

During the course of the program, parents are encouraged to keep track of their children's behavior, as well as their own behavior, and to reflect on what is working with their parenting plan and what is not working as well. Parents then work with their practitioner to fine-tune their plan. Triple P - Standard Level 4 practitioners are trained to work with parents' strengths and to provide a supportive, non-judgmental environment where a parent can continually improve their parenting skills.

Goals

The goals of Triple P- Standard Level 4 treatment are improved child behavior, improved parenting skills, increased parent confidence, and decreased parent stress.

Specific Design of the Service

The Triple P - Standard Level 4 service typically consists of 10 individual sessions with a family. The first two sessions have an assessment component, which involve: parent completion of standardized self-report measures of child adjustment as well as parenting styles; interviews with the parent; interviews with the child when that is appropriate; and behavioral observation of parent/child interactions. Based on information from these multiple sources, clinicians gather information relevant to diagnosis and functional impairment to determine medical necessity and fit of services.

The child's presence during the session is critical during the assessment phase, as well as during the observation practice sessions. During certain session components, the therapist's intervention is directed towards the parent (such as coaching the parent in fine-tuning their implementation of the parenting skills in their parenting plan). During parent-directed interventions, it is recommended that the child be set up with an engaging activity for the period of direct work

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with the parent. Typically, the sessions during which the therapist’s activity is directed primarily toward the parent are conducted during Session 1 (Parent Initial Interview), introducing and teaching parenting skills during Session 3 (Positive Parenting), Session 4 (Managing Misbehavior), and Session 10 (final session and program close). During those parent-directed sessions, ideally the therapist meets with the parent(s) without the child present; if the parent(s) are unable to find childcare for the child during those parent-directed sessions, the parent(s) are encouraged to bring activities to the session to keep the child busy.

Recommended Intensity:

One 60-minute session per week.

Recommended Duration

Triple P Standard Level 4 is designed as a 10-session intervention, with specific tasks and components to be completed in each of the 10 sessions. For children and families with more complex needs who may take longer to master the core positive parenting skills within the Triple P model, certain tasks and components may need to be continued across more than one session, with the result that the treatment episode may take longer than 10 sessions.

If MCO policy requires prior authorization for a treatment episode of Triple P Standard Level 4, the following steps must be taken:

1. The provider requesting prior authorization should note that the evidence-based model Triple P Standard Level 4 is being used. An initial authorization of a minimum of 10 sessions is recommended so that the provider may complete the medically necessary treatment episode and provide evidence-based care to the youth and family; and
2. If additional sessions, beyond the initial authorization, are needed to complete a treatment episode of Triple P Standard Level 4, re-authorization should be requested indicating that the specialty model Triple P Standard Level 4 is being utilized, and should note the reason for a need for additional sessions to complete the treatment episode of evidence-based care.

Delivery Setting

Triple P-Standard Level 4 may be provided in a clinic or a home-based setting.

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Triple P research and evaluation studies have been conducted across many culturally, racially and linguistically diverse contexts, as well as with many different family types (e.g. two-parent, single-parent, and stepparent) and with families of diverse socio-economic status. Studies and evaluations consistently show similar impacts across different cultures. One of the reasons that Triple P is believed to have a wide breadth of cultural relevance is its basis in the self-regulatory framework. Parents set their own goals for themselves and their children, in alignment with their own beliefs and values. They also choose the strategies from the menu of strategies that will best fit their needs and preferences. Another key element for cultural relevance is that practitioners tailor the examples given to fit the particular family’s needs and goals. Practitioners are encouraged to be sensitive to different beliefs, expectations and traditions, and may tailor their delivery to suit different parents. Various parent resources, which are simple and easy-to-follow, have been translated into 21 languages other than English.

Provider Qualifications and Responsibilities**EBP Model Requirements**

To provide Triple P Standard Level 4 under Louisiana Medicaid, the provider must show accreditation by Triple P America (TPA). Triple P America (the dissemination body for Triple P in the US) holds the training and accreditation process for Triple P in the US. Only TPA is allowed to provide training and accreditation for Triple P in the US. Once a practitioner is accredited in Triple P, the accreditation does not expire and there are no further certification requirements.

Other Qualifications and Requirements

Practitioners must meet qualifications and requirements established in the “Outpatient Therapy by Licensed Practitioners” section of this manual.

Allowed Provider Types and Specialties

1. PT 31 Psychologist PS:
 - a. 6A Psychologist – Clinical;
 - b. 6B Psychologist – Counseling;

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- c. 6C Psychologist – School;
 - d. 6D Psychologist – Developmental;
 - e. 6E Psychologist - Non-declared;
 - f. 6F Psychologist – Other; and
 - g. 6G Psychologist – Medical.
2. PT 73 Social Worker (Licensed/Clinical) PS:
- a. 73 Licensed Clinical Social Worker (LCSW); and
 - b. LL Lower Level – Licensed Master Social Worker (LMSW).
3. PT AK Licensed Professional Counselor (LPC) PS:
- a. 8E CSoC/Behavioral Health – LPC; and
 - b. LL Lower Level – Provisionally Licensed Professional Counselor (PLCP).
4. PT AH Licensed Marriage & Family Therapists (LMFT) PS:
- a. 8E CSoC/Behavioral Health – LMFT; and
 - b. LL Lower Level – Provisionally Licensed Marriage and Family Therapist (PLMFT).
5. PT AJ Licensed Addiction Counselor PS 8E CSoC/Behavioral Health;
6. PT 20 Psychiatrist PS:
- a. 26 Psychiatry; and
 - b. 2W Addiction Specialist.
7. PT 78 Nurse Practitioner (APRN) PS 26;

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- 8. PT 93 Clinical Nurse Specialist (APRN) PS 26; and
- 9. PT 94 Physician Assistant PS 26.

Training

The Triple P training process involves both an initial training and an accreditation process. To become accredited in Triple P- Standard Level 4, the practitioner must complete:

- 1. Initial 3-day training;
- 2. Approximately 2 weeks after initial training, a one (1) day Pre-Accreditation Workshop; and
- 3. Approximately 4 weeks later, an additional half (½)-day Accreditation process, including completion of a quiz as well as role-play demonstration of key competencies.

Quality Assurance

Outcomes

Within the Triple P -Level 4 Standard intervention, the outcomes measured are child adjustment, and effective parenting.

Child adjustment should be measured through a pre- and post- administration of a standardized tool to measure child adjustment, by parent report. For youth 2 years old and older, the Strengths and Difficulties Questionnaire (SDQ) may be used as a pre- and post- measure. For youth as young as 18 months, the Early Childhood Screening and Assessment-24 (ECSA-24) may be used.

Effective parenting should be measured through pre- and post- administration of the Parenting Scale.

Model-Specific Documentation Requirements

Triple P has developed “Session Checklists” for each of the 10 sessions in Standard Level 4 sessions. Use of these session checklists allows practitioners to summarize each session, and

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assists practitioners to implement each session as intended. Triple P providers should complete a Session Checklist for each session and keep these in the client record.

These checklists should be completed by the practitioner. They may be completed either solely by the therapists or together with a colleague or supervisor observer. These checklists are both in the Practitioner Manual and downloadable from the Triple P Provider Network.

Session Checklists should be completed for the purposes of maintaining and monitoring fidelity to the Triple P model. Session Checklists are supplemental to, and do not replace, a full progress note documenting each session.

Fidelity

Fidelity to the Triple P model may be monitored as needed via document review of practitioner-completed Session Checklists. While practitioners should aim to complete 100 percent of the items on each Session Checklist, a completion rate of 80 percent of checklist items per session demonstrates acceptable fidelity to the model.

Limitations/Exclusions

Limitations and exclusions noted in the “Outpatient Therapy by Licensed Practitioners” apply.

Billing

1. Only direct staff face-to-face time with the child or family may be billed. Triple P-Standard Level 4 is a face-to-face intervention delivered to the parent/primary caregiver and child dyad, for the benefit of the identified child. When the intervention is provided with both the caregiver(s) and child present, procedure codes for Individual Therapy or Family Therapy with Patient Present may be billed. If the child is not present during a parent-directed intervention component, the appropriate procedure code must be billed, e.g. Family Psychotherapy without Patient Present;
2. Collateral contacts billable to Medicaid should involve contacts with parents, guardians using the appropriate procedure code as stated above. All contacts must be based on goals from the child’s/youth’s treatment plan or plan of care. Phone contacts are not billable;

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NOTE: The exception to the allowance of collateral contacts while providing evidence-based practices is coordination with other child-serving systems such as parole and probation programs, public guardianship programs, special education programs, child welfare/child protective services and foster care programs. Coordination with these child-serving systems is considered collateral contact and may be necessary to meet their goals of the individual, but is not billable through Medicaid. Services may be provided by these child-serving systems, however, the services provided must be funded through the agency providing the service.

3. Therapists bill standard CPT individual and family therapy codes for sessions providing Triple P- Standard Level 4;
4. The EBP tracking code “EB06” should be indicated on claims to note that the therapy session utilized Triple P-Level 4 as an evidence-based model of therapeutic intervention;
5. To use the Triple P-Level 4 tracking code of “EB06” on claims, the therapist must first provide documentation of their accreditation in Triple P- Standard Level 4 (as issued by Triple P America) as part of the therapist’s credentialing package; and
6. LMSWs, PLPCs and PLMFTs may not directly bill for services provided to a Medicaid enrollee. LMSWs, PLPCs and PLMFTs may be the rendering provider on a claim when in accordance with Title 46 and their individual practice act.

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TF-CBT

TRAUMA-FOCUSED COGNITIVE BEHAVIORAL THERAPY

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a conjoint child and parent psychotherapy model for children who are experiencing significant emotional and behavioral difficulties related to traumatic life events. It is a components-based hybrid treatment model that incorporates trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles.

TF-CBT is a model used within the service “Outpatient Therapy by Licensed Practitioners,” so it follows the requirements set out in the “Outpatient Therapy by Licensed Practitioners” section of this manual.

Evaluation of the Evidence Base for the EBP Model

Evaluation of the evidence-base for the TF-CBT model has been conducted by national registries.

TF-CBT has received a CEBC Scientific Rating of 1-Well Supported by Research Evidence by the California Evidence Based Clearinghouse: <https://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy/>

TF-CBT has been independently and systematically reviewed by the Title IV-E Prevention Services Clearinghouse, and has received a rating of “Promising” in the Mental Health Programs and Services category: <https://preventionservices.abtsites.com/programs/119/show>

The model and research evidence for TF-CBT are also described in a fact sheet from The National Child Traumatic Stress Network (NCTSN): https://www.nctsn.org/sites/default/files/interventions/tfcbt_fact_sheet.pdf

Target Population Characteristics

TF-CBT was created for young people who have developed significant emotional or behavioral difficulties following exposure to a traumatic event (e.g., loss of a loved one, physical abuse, sexual abuse, domestic or community violence, motor vehicle accidents, fires, tornadoes, hurricanes, industrial accidents, terrorist attacks).

TF-CBT may benefit children with a known trauma history who are experiencing significant posttraumatic stress disorder (PTSD) symptoms, whether or not they meet full diagnostic criteria. In addition, TF-CBT may benefit children with depression, anxiety, and/or shame related to their

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traumatic exposure. Children experiencing childhood traumatic grief can also benefit from the treatment.

TF-CBT may be delivered to children ages 3-18 and their parents.

TF-CBT may not be appropriate for the following:

1. Acutely suicidal youths;
2. Adolescents with current parasuicidal behaviors (self-cutting or non-fatal self-harm);
3. Youth with extensive inappropriate/illicit substance use;
4. Youth with a history of significant behavioral problems present prior to the trauma exposure; or
5. Youth with significant conduct problems (aggressive, destructive).

Philosophy and Treatment Approach

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is designed to help those 3 to 18-year-olds and their parents overcome the negative effects of traumatic life events, such as child sexual or physical abuse. TF-CBT aims to treat serious emotional problems such as posttraumatic stress, fear, anxiety, and depression by teaching children and parents' new skills to process thoughts and feelings resulting from traumatic events.

TF-CBT is a treatment intervention that integrates cognitive and behavioral interventions with traditional child-abuse therapies. Its focus is to help children talk directly about their traumatic experiences in a supportive environment. TF-CBT components are described by the acronym PRACTICE as follows:

1. **Psychoeducation.** The therapist works with the child and caregiver (typically, separately) to explain and normalize trauma-related symptoms and avoidance, describe the TF-CBT treatment, and build hope;
2. **Parenting.** With the goal of enhancing the parent/child relationship, the therapist teaches and reinforces positive parenting skills. If the child's behavior problems are significant and are of primary concern to the parent, this component should be a priority, and the therapist may consider meeting with the parent first during

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sessions. The therapist will work to link the behaviors to the trauma, during work with the parent;

3. **Relaxation.** The therapist teaches specific skills for calming and reducing distress in the moment;
4. **Affective modulation.** The therapist works to help the child increase the capacity to identify a range of feelings, having a feelings vocabulary, and link feelings to appropriate expression. The child identifies/learns strategies to improve and calm affect, and identify feelings associated with the traumatic event;
5. **Cognitive coping.** The therapist teaches the CBT triangle; the relationship between thoughts, feelings, and behavior. The therapist teaches the child to identify automatic thoughts that cause distress, helps the child understand that thoughts drive feelings and feelings can be changed, and helps the child generate coping self-statements;
6. **Trauma narrative.** Through exposure and cognitive processing, the child is able to think and talk about the trauma, identify trauma-related unhelpful cognitions, and identify more helpful/accurate ways to think about the trauma. The goal is for the child to develop a helpful understanding of what happened, that acknowledges the trauma but does not define the child;
7. **In-vivo exposure.** The therapist helps the child separate harmless situations that trigger fear, from real danger. The therapist helps the child reduce avoidance that interferes with daily functioning;
8. **Conjoint trauma narrative.** The therapeutic session(s) provide the opportunity for the child to share the trauma narrative with key trusted adult(s) and receive validation, praise, and support; and
9. **Enhancing safety.** The therapist helps the child and caregiver create a safety plan to reduce risk of ongoing dangers, and teaches safety skills for use in risky situations.

The program largely operates by seeing the child and the caregiver separately. For example, the first part of the session is with the child, and then the later part of the session is with the parent. This allows for the child to begin talking about thoughts and feelings, without worrying about their caregivers' reactions. The parent component teaches parents parenting skills to provide optimal support for their children. Then, conjoint parent–child session(s) encourage the child to

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discuss the traumatic events directly with the parent, and allows both the parent and child to communicate questions, concerns, and feelings more openly.

Typically, TF-CBT is implemented through 12 to 18 weekly sessions. These aim to provide the parents and children with the skills to better manage and resolve distressing thoughts, emotions, and reactions related to traumatic life events. The sessions also aim to improve the safety, comfort, trust, and growth in the child and develop parenting skills and family communication.

Goals

1. Reduced symptoms of child trauma, PTSD, depression, anxiety;
2. Reduced child externalizing behaviors (including age-inappropriate sexual problem behaviors, if related to the primary trauma); and
3. Improved child adaptive functioning, caregiver parenting skills, caregiver-child communication, and attachment.

Specific Design of the Service

Treatment consists of the following:

1. 60-90 minute sessions weekly:
 - a. Initially, sessions consist of 30-45 minutes of psychoeducation and intervention with the parent, and separately 30-45 minutes of psychoeducation and intervention with the child; and
 - b. Later in treatment, the child and parent may participate together, conjointly, in the full length of the session.
2. TF-CBT therapists assign a homework component, to be completed together (child and caregiver), as well as assignments to be completed separately.

Recommended Intensity

The recommended intensity is one 60-90 minute session per week.

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TF-CBT****Recommended Duration**

The recommended duration is 12-25 sessions.

A course of TF-CBT treatment is typically completed in 12-18 sessions; the duration of treatment will vary based on the extent and complexity of the youth's trauma history.

For youth experiencing complex trauma, research suggests that “the duration of TF-CBT treatment also often needs to be extended to 25 sessions and occasionally up to 28-30 sessions.” (Research by: Cohen, J. A., Mannarino, A. P., Kliethermes, M., & Murray, L. A. (2012). Trauma-focused CBT for youth with complex trauma. *Child abuse & neglect*, 36(6), 528–541. <https://doi.org/10.1016/j.chiabu.2012.03.007>).

If MCO policy requires prior authorization for Outpatient Therapy by Licensed Providers, including treatment episodes of TF-CBT, the following steps must be followed:

1. The provider requesting prior authorization should note that the evidence-based model TF-CBT is being used. An initial authorization of 25 sessions is recommended so that the provider may complete the medically necessary treatment episode and provide evidence-based care to the youth and family; and
2. If additional sessions beyond the initial authorization are needed to complete a treatment episode of TF-CBT, the re-authorization request should indicate that the specialty model TF-CBT is being utilized, and should note the reason for a need for additional sessions to complete the treatment episode of evidence-based care.

Delivery Setting

TF-CBT may be provided in a clinic, home-based, or residential setting.

Cultural Considerations

TF-CBT has been tested in U.S. white, African American and Latino populations as well as in European, Australian and African youth with positive outcomes in multiple domains. TF-CBT has been used with families of diverse SES and religions. TF-CBT includes engagement strategies which specifically ask about the child's and parents cultural practices.

Additional culture-specific information on TF-CBT can be found in a NCTSN fact sheet at: https://www.nctsn.org/sites/default/files/interventions/tfcbt_culture_specific_fact_sheet.pdf

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Provider Qualifications and Responsibilities

Practitioners must meet qualifications and requirements established in the Outpatient Therapy by Licensed Practitioners section of this manual and requires training in the treatment model as minimum requirements.

Allowed Provider Types and Specialties

1. PT 31 Psychologist PS:
 - a. 6A Psychologist – Clinical;
 - b. 6B Psychologist – Counseling;
 - c. 6C Psychologist – School;
 - d. 6D Psychologist – Developmental;
 - e. 6E Psychologist - Non-declared;
 - f. 6F Psychologist – Other; and
 - g. 6G Psychologist – Medical.

2. PT 73 Social Worker (Licensed/Clinical) PS:
 - a. 73 Licensed Clinical Social Worker (LCSW); and
 - b. LL Lower Level – Licensed Master Social Worker (LMSW).

3. PT AK Licensed Professional Counselor (LPC) PS:
 - a. 8E CSoC/Behavioral Health – LPC; and
 - b. LL Lower Level – Provisionally Licensed Professional Counselor (PLPC).

4. PT AH Licensed Marriage & Family Therapists (LMFT) PS:
 - a. 8E CSoC/Behavioral Health – LMFT; and

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- b. LL Lower Level – Provisionally Licensed Marriage and Family Therapist (PLMFT).
- 5. PT AJ Licensed Addiction Counselor PS 8E CSoC/Behavioral Health;
- 6. PT 20 Psychiatrist PS:
 - a. 26 Psychiatry; and
 - b. 2W Addiction Specialist.
- 7. PT 78 Registered Nurse (APRN) PS 26;
- 8. PT 93 Clinical Nurse Specialist (APRN) PS 26; and
- 9. PT 94 Physician Assistant PS 26.

Training

The TF-CBT National Certification Program establishes the following training requirements leading to TF-CBT certification, in the following order:

- 1. Completion of the online training course through TF-CBT Web 2.0;
- 2. Participation in a live, 2-day TF-CBT training conducted by a TF-CBT developer or a nationally-approved TF-CBT trainer;
- 3. Participation in at least 12 follow-up consultation calls with a TF-CBT developer/approved trainer; and
- 4. Completion of three separate TF-CBT treatment cases with three children or adolescents with at least two of the cases including the active participation of caretakers or another designated third party (e.g., direct care staff member in a residential treatment facility), and use of at least one standardized instrument to assess TF-CBT treatment progress with each of the above cases.

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Following these training components, the application process for TF-CBT national certification has two steps:

1. Part 1 requires therapists to document completion of the above training components, upon which candidates then become eligible to take the TF-CBT Therapist Certification Program Knowledge-Based Test; and
2. Passing the knowledge-based test is Part 2 of the application for certification.

TF-CBT certification is good for five (5) years. At five (5)-years post-certification, TF-CBT therapists must complete three (3) modules of re-certification education, whereupon they can be re-certified for another five (5) years.

Certified TF-CBT therapists are listed on a national registry at <https://tfcbt.org/members/>

Quality Assurance

Outcomes

The primary outcome measured in TF-CBT treatment is the effect of treatment on trauma symptoms. TF-CBT providers should obtain child self-report of trauma symptoms at pre- and post-treatment:

1. The Child PTSD Symptoms Scale for the DSM-5 (CPSS-5) can be used as a self-report measure for children between the ages of 8 and 18; and
2. For younger children, TF-CBT providers should obtain parent report of youth trauma symptoms using the Young Child PTSD Checklist (YCPC).

For children where behavior problems are also a primary concern in treatment, child behavior outcomes may be measured at pre- and post-treatment as well. A standardized behavioral inventory, such as the CBCL (Child Behavior Checklist) or the SDQ (Strengths and Difficulties Questionnaire), may be used for this purpose.

Model-Specific Documentation Requirements

The TF-CBT Brief Practice Checklist is a self-report form that is available in Appendix 4 of the TF-CBT Implementation Manual. The Brief Practice Checklist should be completed by the therapist or supervisor after each session, to indicate which TF-CBT components were implemented during the session. For each TF-CBT component that are checked off on the Brief

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Practice Checklist as having been used during the session, the progress note should then provide detail on how the component was implemented and the client’s response. The Brief Practice Checklist should be kept in the client chart along with the progress notes for each session.

Fidelity

Fidelity to the TF-CBT model may be reviewed as needed by reviewing treatment records. Records should demonstrate that: the TF-CBT provider used the TF-CBT Brief Practice Checklist to specify which components were used in each session; the therapist detailed in progress notes how those components were implemented in each session; and over the course of a completed case that the therapist used the majority of the PRACTICE components to treat the child or youth.

The TF-CBT National Certification Program does not require post-certification fidelity monitoring. The TF-CBT National Certification Program does require therapists to re-certify every five (5) years, by providing evidence of completion of three (3) modules of re-certification education.

Limitations/Exclusions

Limitations and exclusions noted in the “Outpatient Therapy by Licensed Practitioners” apply.

Billing

1. Only direct staff face-to-face time with the child or family may be billed. TF-CBT is a face-to-face intervention with the individual and caregiver present; however, the child receiving treatment does not need to be present for all contacts:
 - a. Typical sessions during which there is both a child-delivered portion of the session, and a parent-delivered portion of the session, may be billed as 90832, 90834, or 90837 (or their successors) – Psychotherapy, with patient present, as long as:
 - i. The client is present for all or the majority (greater than 50 percent) of the time billed; and
 - ii. The entirety of the service is provided to, or directed exclusively toward the treatment of, the Medicaid-eligible child or youth.

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- b. If there is a parent-directed session for which the child is not present for the majority of the time, the appropriate procedure code must be billed, e.g. 90846 (or its successor)– Family Psychotherapy without Patient Present:
 - i. The parent-directed session must be directed exclusively toward the treatment of the Medicaid-eligible child or youth.
- 2. Collateral contacts billable to Medicaid should involve contacts with parents or guardians using the appropriate procedure code as stated above. All contacts must be based on goals from the child’s/youth’s plan of care. Phone contacts are not billable;

NOTE: The exception to the allowance of collateral contacts while providing evidence-based practices is coordination with other child-serving systems such as parole and probation programs, public guardianship programs, special education programs, child welfare/child protective services and foster care programs. Coordination with these child-serving systems is considered collateral contact and may be necessary to meet their goals of the individual, but is not billable through Medicaid. Services may be provided by these child-serving systems; however, the services provided must be funded through the agency providing the service.

- 3. Therapists bill standard CPT individual and family therapy codes for sessions providing TF-CBT;
- 4. The EBP tracking code “EB07” should be indicated on claims to note that the therapy session utilized TF-CBT as an evidence-based model of therapeutic intervention;
- 5. To use the TF-CBT tracking code of “EB07” on claims, the therapist must first provide documentation of national certification in TF-CBT, as part of the therapist’s credentialing package. Certified TF-CBT therapists are listed on a national registry at <https://tfcbt.org/members/>; and
- 6. LMSWs, PLPCs and PLMFTs may not directly bill for services provided to a Medicaid enrollee. LMSWs, PLPCs and PLMFTs may be the rendering provider on a claim when in accordance with Title 46 and their individual practice act.

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**EYE MOVEMENT DESENSITIZATION AND REPROCESSING
THERAPY (EMDR THERAPY)**

Eye Movement Desensitization and Reprocessing (EMDR) Therapy is an evidence-based psychotherapy that treats trauma-related symptoms.

EMDR therapy is designed to resolve unprocessed traumatic memories in the brain. The therapist guides the client to process the trauma by attending to emotionally disturbing material in brief, sequential doses, and while at the same time focusing on an external stimulus. The most commonly used external stimulus in EMDR therapy is alternating eye movements; however, sounds or taps may be used as well.

EMDR therapy is a model used within the service Outpatient Therapy by Licensed Practitioners, and follows the requirements set out in the “Outpatient Therapy by Licensed Practitioners” section of this manual.

Evaluation of the Evidence Base for the EBP Model

Evaluation of the evidence-base for the EMDR model has been conducted by several national registries.

EMDR therapy for the treatment of children and adolescents has received a CEBC Scientific Rating of 1-Well Supported by Research Evidence by the California Evidence Based Clearinghouse: <https://www.cebc4cw.org/program/eye-movement-desensitization-and-reprocessing/>

The California Evidence Based Clearinghouse also reviewed the evidence on EMDR therapy for the treatment of adults, and gives a Scientific Rating of 1-Well Supported by Research Evidence: <https://www.cebc4cw.org/program/eye-movement-desensitization-and-reprocessing-for-adults/>

In 2010, EMDR therapy was reviewed and included in the Substance Abuse and Mental Health Services Administration’s National Registry of Evidence-based Programs and Practices, and EMDR therapy was reviewed as part of SAMHSA’s Comparative Research Effectiveness Series: https://cdn.ymaws.com/www.emdria.org/resource/resmgr/research/treatment_guidelines/samhsa_2012.nrepp-comparativ.pdf

EMDR therapy was given a Strong Recommendation as an effective treatment for PTSD in children, adolescents and adults by the International Society of Traumatic Stress Studies:

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http://www.istss.org/getattachment/Treating-Trauma/New-ISTSS-Prevention-and-Treatment-Guidelines/ISTSS_PreventionTreatmentGuidelines_FNL-March-19-2019.pdf.aspx

EMDR therapy is often cited as an effective treatment in national and international treatment guidelines for organizations such as the U.S. Department of Veteran Affairs and the U.S. Department of Defense: <https://www.healthquality.va.gov/guidelines/MH/ptsd/>

Target Population Characteristics

Children, adolescents and adults. EMDR therapy may be used with children as young as two years of age, through adolescence and adulthood.

Scientific research has established EMDR therapy as clearly effective for post-traumatic stress and trauma-related symptoms. Trauma may result from a single event, multiple events or a series of events chronic in nature.

Clinicians have also reported success using EMDR therapy in treatment of the following conditions:

1. Anxiety, panic attacks, and phobias;
2. Chronic Illness and medical issues;
3. Depression and bipolar disorders;
4. Dissociative disorders;
5. Eating disorders;
6. Grief and loss;
7. Pain;
8. Performance anxiety;
9. Personality disorders;
10. Sleep disturbance; and
11. Substance abuse and addiction.

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Philosophy and Treatment Approach

Using standardized procedures, EMDR therapy helps the client access stored memories, activate the brain’s information system and, through reprocessing, helps move the disturbing information to adaptive resolution.

The model on which EMDR therapy is based, Adaptive Information Processing (AIP), posits that much of psychopathology is due to the maladaptive encoding of and/or incomplete processing of traumatic or disturbing adverse life experiences. This impairs the client’s ability to integrate these experiences in an adaptive manner. The eight-phase, three-pronged process of EMDR therapy facilitates the resumption of normal information processing and integration. This treatment approach, which targets past experience, current triggers, and future potential challenges, results in the alleviation of presenting symptoms, a decrease or elimination of distress from the disturbing memory, improved view of the self, relief from bodily disturbance, and resolution of present and future anticipated triggers.

Goals

The overall goal of EMDR therapy is to fully process pathogenic memories and experiences and sort out the emotions attached to those experiences.

After effective EMDR therapy, the client is expected to experience:

1. Relief from distress and physiological arousal; and
2. Replacement of negative thoughts and feelings that are no longer useful, with positive thoughts and feelings that will encourage healthier behavior and social interactions.

Specific Design of the Service

The EMDR treatment approach follows a three-pronged protocol to target and reprocess each presenting complaint. The protocol requires 1) attention to past experiences as the basis for clinical complaints; 2) attention to current situations that trigger dysfunctional emotions, beliefs, and sensations; and 3) attention to positive experiences to enhance future adaptive behaviors and mental health.

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During EMDR therapy, the therapist guides the client through 30-second exercises using bilateral eye movements, tones, or taps while the client focuses on the target disturbing experience and then on any related negative thoughts, associations, and body sensations. Through adaptive information processing, the dual-attention exercises disrupt the client's stored memory of the trauma to facilitate an elimination of negative beliefs, emotions, and somatic symptoms associated with the memory as it connects with more adaptive information stored in the memory networks. Once recall of the trauma no longer elicits negative beliefs, emotions, or somatic symptoms, and the memory simultaneously shifts to a more adaptive set of beliefs, emotions, and somatic responses, it is stored again, replacing the original dysfunctional memory of the trauma.

EMDR treatment proceeds in eight phases:

Phase 1: History-taking. A psychosocial interview is conducted to evaluate the patient's presenting issues, self-soothing skills, and readiness for reprocessing, and to develop treatment goals. The clinician gathers information required for informed consent, considers special EMDR therapy criteria related to client selection and readiness, and identifies potential treatment targets from positive and negative events in the patient's life (past, present, and future).

Phase 2: Preparation. During the second phase of treatment, the therapist prepares the client for EMDR processing of traumatic targets through psychoeducation, strengthening the relationship between the clinician and the patient, setting expectations for the course of treatment, and identifying coping skills for use during and between treatment sessions.

Phases 3-6: Assessment, Desensitization, Installation, and Body Scan. In phases three through six, a target memory is identified with the client identifying the image that represents the worst part of the disturbing event, the negative cognition associated with the image, and a positive cognition that the client would like to believe instead. The client is also asked to identify emotions and body sensations associated with the target memory.

After this, the client is instructed to focus on the image, negative thought, and body sensations while simultaneously engaging in EMDR processing using sets of bilateral stimulation. These sets may include eye movements, taps, or tones. The type and length of these sets is different for each client, and determined in collaboration between the client and therapist.

After each set of stimulation, the clinician instructs the client to notice whatever thought, feeling, image, memory, or sensation comes to mind, while maintaining dual awareness of the past and the present. Depending upon the client's report, the clinician will choose the next focus of attention. These repeated sets with directed focused attention occur numerous times throughout

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the session. If the client becomes distressed or has difficulty in progressing, the therapist follows established procedures to help the client get back on track.

When the client reports no distress related to the targeted memory, they are asked to think of the preferred positive belief that was identified at the beginning of the session. At this time, the client may adjust the positive belief if necessary, and then focus on it during the next set of bilateral stimulation until it feels completely true. After installing the positive cognition with bilateral stimulation, then the client is asked to consider the distress in their body. Bilateral stimulation is used in the same way to desensitize and clear the body of the body memories. Once the body is clear, it is considered a complete processing session.

If the target is not completely processed, it is considered an incomplete session and various resources are utilized to help the client successfully leave the session to work at another time on the target.

Phase 7: Closure, with an incomplete or complete processing session. In this stage, there is reorientation of the focus of attention to bring closure to the reprocessing. The client is stabilized and the session closed, with reorientation to the present. A plan is developed for the time between sessions, and as appropriate, a plan is arranged for contact with the clinician.

Phase 8: Reevaluation. Phase 8 is often conducted at the beginning of a subsequent treatment session. At the outset of an individual therapy session, the therapist will revisit the impact of previous sessions. Reevaluation ensures clinical attention and follow-up of every EMDR treatment session to evaluate specific target memories, identify other relevant associations that may have developed as a result of reprocessing, and evaluate patient progress.

Adaptions for EMDR Therapy with Children

Dual Attention Stimulation (DAS) or bilateral stimulation refers to the use of alternating, right-left tracking that may take the form of eye movements, tones or music delivered to each ear, or tactile stimulation, such as alternating hand taps. Creative alternatives have been developed for children that incorporate Dual Attention Stimulation through the use of puppets, stories, dance, and art.

Recommended Intensity

EMDR therapy was developed as an intervention to be delivered in 50-90 minute therapy sessions.

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Sessions may be spaced in the more traditional model of weekly sessions, or more frequently as needed. When shorter (45-60 minute) sessions are used, it may be most effective to increase the frequency of sessions to 2 times per week. The appropriate length and timing should be decided between the client and therapist, to meet the client’s needs.

Recommended Duration

The course of treatment includes a history assessment and preparation, a series of reprocessing and desensitization sessions, and a reevaluation to confirm that adaptive information processing was successful and persists. Treatment concludes when the client no longer reports disturbance or negative cognitions associated with the traumatic memory.

Length of treatment is not prescribed and is dependent upon the severity of the trauma as well as other factors. The number of sessions required to reprocess traumatic memories are fewer for patients with a single trauma to reprocess, while more sessions are required for clients with multiple traumas. Based on individual needs, average duration of a treatment episode of EMDR Therapy may range from approximately 5 to approximately 20 sessions.

If MCO policy requires prior authorization for Outpatient Therapy by Licensed Providers, including treatment episodes of EMDR Therapy:

1. The provider requesting prior authorization should note that the evidence-based model EMDR Therapy is being used. An initial authorization of 20 sessions is recommended so that the provider may complete the medically necessary treatment episode and provide evidence-based care to the member; and
2. If additional sessions beyond the initial authorization are needed to complete a treatment episode of EMDR Therapy, the re-authorization request should indicate that the specialty model EMDR Therapy is being utilized, and should note the reason for a need for additional sessions to complete the treatment episode of evidence-based care.

Delivery Setting

EMDR therapy may be used in outpatient clinics, as well as in crisis settings, inpatient, or residential care settings.

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Cultural Considerations

EMDR therapy is an approach to psychotherapy that has been practiced in the U.S. and around the world. EMDR treatment has been tested and has demonstrated effectiveness with a variety of populations including children and adults of different racial and ethnic backgrounds.

The EMDRIA Statement Regarding Diversity and Cultural Competence (accessed at <https://www.emdria.org/page/diversitystatement>) states that “EMDRIA values cultural competence... as a core component of effective EMDR therapy... EMDRIA strives to educate and support EMDR clinicians as they implement culturally attuned EMDR therapy.”

Provider Qualifications and Responsibilities**EBP Model Requirements**

EMDRIA (EMDR International Association) sets the standards and requirements for EMDR therapy training. EMDRIA certifies individual clinical practitioners in the practice of EMDR therapy by ensuring all basic requirements, initial training, and ongoing certification are met (see www.emdria.org).

EMDRIA establishes two levels of training for practitioners in EMDR therapy. For the purposes of providing EMDR therapy under Louisiana Medicaid, either level (EMDRIA Approved Basic Training, or EMDR Certification) are acceptable qualifications.

The standard level of training, which allows a practitioner to provide EMDR therapy, is referred to as “EMDRIA Approved Basic Training.”

Following completion of EMDR Basic Training, a practitioner may go on to achieve a more advanced level of training, referred to as “EMDR Certification.” Once Certified in EMDR therapy, practitioners must re-certify every 2 years.

Other Qualifications and Requirements

Practitioners must meet qualifications and requirements established in the Outpatient Therapy by Licensed Practitioners section of this manual.

Allowed Provider Types and Specialties

1. PT 31 Psychologist PS:

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- a. 6A Psychologist – Clinical;
 - b. 6B Psychologist – Counseling;
 - c. 6C Psychologist – School;
 - d. 6D Psychologist – Developmental;
 - e. 6E Psychologist - Non-declared;
 - f. 6F Psychologist – Other; and
 - g. 6G Psychologist – Medical.
2. PT 73 Social Worker (Licensed/Clinical) PS:
- a. 73 Licensed Clinical Social Worker (LCSW); and
 - b. LL Lower Level – Licensed Master Social Worker (LMSW).
3. PT AK Licensed Professional Counselor (LPC) PS:
- a. 8E CSoC/Behavioral Health – LPC; and
 - b. LL Lower Level – Provisionally Licensed Professional Counselor (PLPC).
4. PT AH Licensed Marriage & Family Therapists (LMFT) PS:
- a. 8E CSoC/Behavioral Health – LMFT; and
 - b. LL Lower Level – Provisionally Licensed Marriage and Family Therapist (PLMFT).
5. PT AJ Licensed Addiction Counselor PS 8E CSoC/Behavioral Health;
7. PT 20 Psychiatrist PS:

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- a. 26 Psychiatry; and
 - b. 2W Addiction Specialist.
- 8. PT 78 Nurse Practitioner (APRN) PS 26;
 - 9. PT 93 Clinical Nurse Specialist (APRN) PS 26; and
 - 10. PT 94 Physician Assistant PS 26.

Training

Training in EMDR therapy should be provided by an EMDRIA Approved Consultant who has maintained active status. EMDRIA Approved Consultants can be located at the EMDRIA website at www.emdria.org.

The first level of EMDR therapy training is “EMDRIA Approved Basic Training.” According to EMDRIA, EMDR Basic Training consists of the following minimum requirements:

- 1. Instruction (20 hours), using the EMDRIA Approved Basic Training Curriculum;
- 2. Supervised Practicum (20 hours); and
- 3. Consultation (10 hours).

An EMDRIA Approved Basic Training provides clinicians with the knowledge and skills to utilize EMDR therapy, a comprehensive understanding of case conceptualization and treatment planning, and the ability to integrate EMDR therapy into their clinical practice. An EMDRIA Approved EMDR Training provides, at a minimum: instruction in the current explanatory model, methodology, and underlying mechanisms of EMDR therapy through lecture, practice, and integrated consultation. Participants receive a certificate of completion of the training when completed in full. Participants who begin EMDR Basic Training must complete the entire training within 24 months from their initial start date.

A more advanced level of EMDR training is EMDR Certification. To achieve EMDR Certification, a therapist currently must:

- 1. Be licensed or certified in their mental health professional field for independent practice and have a minimum of two years’ experience in that field;

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2. Complete an EMDRIA Approved Basic Training;
3. Conduct a minimum of fifty clinical sessions in which EMDR therapy was utilized, with at least 25 clients;
4. Receive twenty hours of consultation in EMDR therapy by an Approved Consultant. At least 10 of these hours must be obtained through individual, EMDR-focused consultation. The remaining 10 hours may be obtained through small group consultation. Consultation groups cannot exceed more than 8 participants at a time;
5. To show continuing education for this credential, the therapist must complete twelve hours of continuing education in EMDR therapy every two years;
6. Completion of 12 hours of EMDRIA Credits (continuing education in EMDR); and
7. Applicants must read and verify on the application form that they agree to adhere to [EMDRIA Policies](#).

EMDRIA Certification must be renewed every two years and requires 12 EMDRIA Credit hours every two years. Certified EMDR Therapists must adhere to [EMDRIA Policies](#), reviewed at the time of application.

Quality Assurance

Outcomes

The primary outcome measured in EMDR treatment is the effect of treatment on trauma symptoms. EMDR therapy providers should obtain a report of trauma symptoms at pre- and post- treatment.

For children, the following scales are appropriate:

1. The Child PTSD (Post Traumatic Stress Disorder) Symptoms Scale for the DSM-5 (CPSS-5) can be used as a self-report measure for children between the ages of 8 and 18; and

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2. For younger children, EMDR providers should obtain parent report of youth trauma symptoms using the Young Child PTSD Checklist (YCPC).

For adults, the following scale is appropriate:

1. PTSD Checklist for DSM-5 (PCL-5).

Model-Specific Documentation Requirements

Templates are available, but not required, to assist EMDR therapists to document the phases of EMDR treatment.

Fidelity

During an EMDRIA Approved Basic Training course, therapist fidelity to the model is supported and monitored during Supervised Practicum (20 hours) and Consultation (10 hours).

If therapists go on to achieve EMDR Certification, their fidelity to the model is supported and monitored during an additional 20 hours of consultation.

EMDRIA does not require fidelity monitoring post-training or certification. However, Certified EMDR therapists receive additional support for EMDR fidelity by completing 12 hours of EMDR-specific continuing education in order to re-certify every 2 years.

Limitations/Exclusions

Limitations and exclusions noted in the “Outpatient Therapy by Licensed Practitioners” apply.

Billing

1. Only direct staff face-to-face time with the individual or family may be billed. EMDR therapy is a face-to-face intervention with the individual present;
2. Therapists bill standard CPT therapy codes for sessions providing EMDR therapy;
3. The EBP tracking code “EB08” should be indicated on claims to note that the therapy session utilized EMDR as an evidence-based model of therapeutic intervention;

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4. To use the EMDR tracking code of “EB08” on claims, the therapist must first provide documentation of completion of EMDRIA Approved Basic Training, as part of the therapist’s credentialing package; and
5. LMSWs, PLPCs and PLMFTs may not directly bill for services provided to a Medicaid enrollee. LMSWs, PLPCs and PLMFTs may be the rendering provider on a claim when in accordance with Title 46 and their individual practice act.

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DIALECTICAL BEHAVIORAL THERAPY

Dialectical Behavioral Therapy (DBT) is a comprehensive, multi-diagnostic, modularized behavioral intervention designed to treat both adults and children/adolescents with severe mental disorders and uncontrolled cognitive, emotional and behavior patterns, including suicidal and/or self-harming behaviors.

DBT was originally developed as a treatment for individuals with Borderline Personality Disorder (BPD). BPD is characterized by a range of self-destructive behaviors (potentially including self-injury, suicidality, substance use, as well as problems in interpersonal relationships) which may be best understood as the consequences of the inability to effectively regulate emotions. These deficits are often the result of biological emotional sensitivity paired with an environment that was not responsive during childhood. Over the years, DBT has demonstrated effectiveness for a wide range of disorders, most of which are associated with difficulties in regulating emotions and associated cognitive and behavioral patterns.

DBT is a research-based, empirically validated treatment delivered via four modalities – individual therapy, group skills training, telephone coaching and participation by DBT-trained providers in weekly ‘Consultation Team’ meetings.

DBT is a model used within the service set for outpatient therapy by licensed practitioners. See Section 2.3 -Outpatient Therapy by Licensed Practitioners of this manual chapter.

Evaluation of the Evidence Base for the DBT Model

Evaluation of the evidence base for the DBT model has been conducted by national registries.

DBT is listed as an evidence-based practice by the following national registries:

1. National Registry of Evidence-based Programs and Practices (NREPP);
2. California Evidence-Based Clearinghouse for Child Welfare; and
3. Suicide Prevention Resource Center.

National Registry of Evidence-based Programs and Practices (NREPP)

SAMHSA’s National Registry of Evidence-based Programs and Practices (NREPP) scored DBT in 2006 as a “highest rated” practice, with a rating of 3.7 out of 4 in terms of the quality of

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evidence showing DBT’s effectiveness in reducing suicide attempts. This review gave strong ratings to DBT in terms of the quality of evidence for DBT’s effectiveness treating non-suicidal self-injury, psychosocial adjustment, treatment retention, drug use, and symptoms of eating disorders. SAMHSA is no longer updating NREPP program descriptions; however, the archived NREPP program description can be found here:

<https://sprc.org/wp-content/uploads/2023/01/Dialectical-Behavior-Therapy-NREPP-Legacy-Listing.pdf>.

DBT has been implemented and evaluated in therapeutic settings in numerous countries. Service settings include inpatient, outpatient, and other community settings and across different genders, races/ethnicities, and age groups. Adaptations of DBT have been developed for numerous populations and presenting problems.

California Evidence-Based Clearinghouse for Child Welfare

<https://www.cebc4cw.org/program/dialectical-behavior-therapy-dbt/>

DBT is listed on the CEBC, and is rated as “Promising Research Evidence.”

Suicide Prevention Resource Center (SPRC)

<https://www.sprc.org/resources-programs/dialectical-behavior-therapy>

SPRC designated this intervention as a “program with evidence of effectiveness” based on its inclusion in SAMHSA’s National Registry of Evidence-Based Programs and Practices (NREPP).

Target Population Characteristics

DBT was created for use with children, adolescents, and adults as a treatment for people with multiple, severe problems across multiple domains of functioning, which may include, but are not limited, to the following:

1. Borderline Personality Disorder;
2. Suicide and parasuicide;
3. Drug dependence;
4. Major drug dependence;
5. Opiate use;

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6. Eating disorders;
7. Emotional dysregulation;
8. Impulsiveness;
9. Anger;
10. Interpersonal aggression; and
11. Trauma.

DBT may require adaptation for use with individuals with a psychotic disorder; these individuals will need additional support, or have their psychotic disorder symptoms well-managed concurrent with DBT.

There is a sizable and growing body of literature demonstrating the effectiveness of DBT in persons with mild or moderate intellectual disabilities and in persons with Autism Spectrum Disorders (ASDs). With adaptations, DBT shall be considered as a legitimate therapy option for persons with intellectual disabilities.

Philosophy and Treatment Approach

DBT is a cognitive-behavioral treatment approach with two key characteristics: a behavioral, problem-solving focus, blended with acceptance-based strategies, and an emphasis on dialectical processes. A “dialectical approach” is taken to treat patients with multiple disorders and to encourage flexibility in thought processes and behavioral styles used in the treatment strategies.

Comprehensive DBT addresses five components, or functions, of treatment:

1. Capability enhancement (skills training);
2. Motivational enhancement (individual behavioral treatment plans);
3. Generalization (access to therapist outside clinical setting, homework, and inclusion of family in treatment);

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4. Structuring of the environment (programmatic emphasis on reinforcement of adaptive behaviors); and
5. Capability and motivational enhancement of therapists (therapist team consultation group).

DBT emphasizes balancing behavioral change, problem-solving, and emotional regulation with validation, mindfulness, and acceptance of clients.

Goals

Behaviors targeted in individual therapy sessions are as follows:

1. Eliminate life-threatening behavior;
2. Reduce therapy-interfering behavior;
3. Reduce quality of life-interfering behavior; and
4. Increase behavioral skills.

DBT targets these behaviors in the service of achieving DBT’s main goal, which is defined as the individual in treatment creating “a life worth living.”

Specific Design of the Service

The DBT program ensures there is a designated DBT primary therapist (usually the client’s individual therapist) for each beneficiary. The DBT Team follows the Linehan model in the provision of DBT services which consists of:

- 1. Individual therapy with a DBT-trained therapist**

An individual therapy session, typically provided for one hour per week, would include the clinician and client. Portions of a session may include important members who support the client (caregivers, other providers), as needed. These sessions focus on engagement, motivation, assessment, and tailoring of cognitive-behavioral strategies to each client. Clients are taught how to identify and measure progress toward goals, assess problems, and solve problems within sessions. The individual therapist is available to clients outside of session times,

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to motivate and coach clients, avoid higher levels of care, and achieve generalization of skills into everyday life.

2. DBT skills training group

A DBT skills training group is a 120-150-minute session held weekly in a group format, with all clients participating in comprehensive DBT. Group time is divided in half, with an hour to review homework from the past week, and an hour to teach new skills and assign homework for the next week. There is often a short break between the hours, if they are taught consecutively. Group is led by two co-leaders, who each have separate roles to perform. Groups are limited in size to enable the group to function well and to allow each client to share about their homework every week. DBT experts suggest that DBT skills-training groups are most effective with at least two participants; there is no strict maximum number of clients in a DBT skills training group, but keeping the group to 12 or fewer participants is good practice. The focus of group is to teach new skills to address potential client deficits in the areas of mindfulness, relationships, emotion regulation, and crisis management. Handouts are provided to clients, and these plus the lecture points to be covered are found in manuals published by Linehan for adults and Rathus and Miller and Linehan for adolescents.

For the treatment of adolescents, it is highly recommended that the skills training group be a multifamily skills training group, to include as active participants both the adolescent and their caregiver(s). In the multifamily group format, caregivers learn and practice skills alongside their adolescent, helping caregivers to be better able to support the youth as they apply DBT strategies to their daily lives, and also allows caregivers to learn skills for their own use managing difficult emotions in interactions with their adolescent. The caregiver participating with their adolescent in the multifamily group, must be the same caregiver to participate throughout the duration of the group. In the case of a multifamily group with both adolescent and caregiver participation, a recommended best practice is to keep the group to seven (7) or fewer adolescent participants, each with one caregiver participating as well.

3. Telephonic, therapeutic coaching (24-hour availability)

A DBT program professional, usually the client's individual therapist, is available by telephone to each client to extend problem-solving and coach the use of skills in real-world situations. DBT coaching is not therapy, but instead is brief,

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targeted, and specific support, aimed to help the DBT client generalize skillful behavior in all relevant contexts. Coaching may be conducted via text message. The amount and type of coaching may be tailored to meet individual client needs, and may include planned, proactive check-ins, and/or being available to the client in the midst of a crisis. If the coaching is provided by a professional who is not the client’s primary therapist (for instance, if coaching is provided by agency staff who rotate in availability for after-hours coverage), then the coaching response shall follow guidance from a detailed, client-specific DBT crisis plan completed by the client’s individual therapist.

Recommended Intensity

1. Individual sessions are recommended for one hour per week; and
2. Group therapy sessions are 120 to 150 minute weekly sessions in a group format.

Recommended Duration

A course of DBT treatment is typically completed in 6-12 months but may be extended for additional 6-month time periods; the duration of treatment will vary based on the extent and complexity of need.

If MCO policy requires prior authorization for outpatient therapy by licensed providers, including treatment episodes of DBT:

1. The provider requesting prior authorization must note that the evidence-based model DBT is being used. An initial authorization to cover a 6-month episode of treatment is recommended so that the provider may complete the medically necessary treatment episode and provide evidence-based care to the individual. A typical 6-month episode of treatment may include:
 - a. Individual therapy sessions: 4 pre-treatment sessions, 24-25 treatment sessions, 3-4 termination sessions; and
 - b. DBT skills training group (group therapy): 24-25 sessions.
2. If additional sessions beyond the initial authorization are needed to complete a treatment episode of DBT, the re-authorization request must indicate that the

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specialty model DBT is being utilized, and must note the reason for a need for additional sessions to complete the treatment episode of evidence-based care.

Delivery Setting

As an outpatient therapy service delivered by licensed practitioners, allowed modes of delivery include individual, family, and group, on-site, off-site, and tele-video. Telehealth delivery is allowed if it includes synchronous, interactive, real-time electronic communication comprising both audio and visual elements.

A comprehensive DBT program is typically provided in an outpatient setting. Telehealth is an allowed modality, and use of telehealth for DBT skills training groups in particular may support continued and consistent client engagement, especially when travel or transportation is a barrier to client engagement.

Components of DBT may be delivered, with some adaptation, in a residential or inpatient setting; however, this would not be billed as a separate service, instead would be part of the active treatment plan reimbursed as part of the comprehensive inpatient or psychiatric residential treatment facility (PRTF) rate.

Cultural Considerations

DBT has been demonstrated to work across numerous populations and is amenable to cultural adaptations. DBT has been evaluated and found to be effective with individuals from diverse backgrounds in regard to age, gender, sexual orientation, and ethnicity, including children (seven to twelve year olds) and adolescents (twelve to eighteen year olds). DBT was originally developed in the United States but has since been researched and evaluated around the world, including randomized control trials in Australia, Europe, South America, and Asia. Research trials have shown that DBT can be implemented effectively across cultures.

Provider Qualifications and Responsibilities

Staff Qualifications

Delivery of the comprehensive DBT model requires a team, preferably with 4-6 clinicians trained and qualified to provide DBT individual therapy.

DBT teams may be comprised of LMHP clinicians licensed for independent practice, or may be comprised of a mix of LMHP clinicians alongside other licensed practitioners, which may include

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staff licensed as a Provisionally Licensed Professional Counselor (PLPC), Provisionally Licensed Marriage and Family Therapist (PLMFT), or Licensed Master Social Worker (LMSW). For DBT teams comprised of a mix of LMHPs and other licensed practitioners, there must be a minimum of two (2) LMHPs on the DBT team.

Staff Supervision for Non-LMHP Staff

Provisionally Licensed Professional Counselor (PLPC), Provisionally Licensed Marriage and Family Therapist (PLMFT), or Licensed Master Social Worker (LMSW) delivering DBT services must be under regularly scheduled supervision in accordance with requirements established by the practitioner's professional licensing board. Proof of the board approved supervision must be held by the provider agency employing these staff. For the psychology intern, the supervisory plan is acceptable.

EBP Model Requirements

To be considered a comprehensive DBT program with fidelity to the evidence-based model, DBT must be delivered by a team of clinicians, and must include the following four (4) core components:

1. **Individual therapy with a DBT-trained therapist:** Typically provided for one hour per week, face-to-face (including telehealth) with a DBT - qualified clinician and client;
2. **Telephonic, therapeutic consultation/support/coaching (24-hour availability):** A DBT program professional, usually the individual therapist, is available by telephone to each client at all times during the week, to extend problem-solving and coach skills to be used in real-world situations;
3. **DBT skills training group:** Typically 120-150-minute session held weekly in a group format, with all clients participating. Group is led by two co-leaders. For the treatment of adolescents, it is highly recommended that the skills training group be a multifamily skills training group, to include as active participants both the adolescent and a caregiver; and
4. **Peer consultation team meetings:** Each DBT team member (individual therapist, skills group co-leaders) participates in a weekly, one-hour consultation team meeting with other DBT practitioners in the same program. Teams are small enough that each provider can provide an agenda item most weeks. The hour-long

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meeting is used for peer consultation, following DBT model guidelines. The team may meet for a second hour, to be used to provide training to providers, where necessary. This format can be run consecutively or as two separate meetings in a week.

Other Qualifications and Requirements

Practitioners must meet qualifications and requirements established in Section 2.3 -Outpatient Therapy by Licensed Practitioners of this manual chapter and requires training in the treatment model as minimum requirements. A graduate degree in a mental health field is required.

Allowed Provider Types and Specialties

1. PT 31 Psychologist PS:
 - a. 6A Psychologist – Clinical;
 - b. 6B Psychologist – Counseling;
 - c. 6C Psychologist – School;
 - d. 6D Psychologist – Developmental;
 - e. 6E Psychologist - Non-declared;
 - f. 6F Psychologist – Other; and
 - g. 6G Psychologist – Medical.

2. PT 73 Social Worker (Licensed/Clinical) PS:
 - a. 73 Licensed Clinical Social Worker (LCSW); and
 - b. LL Lower Level – Licensed Master Social Worker (LMSW).

3. PT AK Licensed Professional Counselor (LPC) PS:

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- a. 8E CSoC/Behavioral Health – LPC; and
- b. LL Lower Level – Provisionally Licensed Professional Counselor (PLPC).
- 4. PT AH Licensed Marriage & Family Therapists (LMFT) PS:
 - a. 8E CSoC/Behavioral health – LMFT; and
 - b. LL Lower Level – Provisionally Licensed Marriage and Family Therapist (PLMFT).
- 5. PT AJ Licensed Addiction Counselor PS 8E CSoC/Behavioral Health;
- 6. PT 20 Psychiatrist PS:
 - a. 26 Psychiatry; and
 - b. 2W Addiction Specialist.
- 7. PT 78 Registered Nurse (APRN) PS 26; and
- 8. PT 93 Clinical Nurse Specialist (APRN) PS 26.

Training

Training and resulting qualification to provide the DBT service under Louisiana Medicaid can be achieved in several ways.

DBT-Linehan Board of Certification

DBT-Linehan Board of Certification (DBT-LBC) is a nationally-recognized source of qualification to provide DBT therapy certification. Training requirements for DBT-Linehan Board certification are a minimum of 40 DBT-specific didactic hours, 12 months of DBT team experience, clinical experience in DBT, skills training through homework assignments during training, a written exam, videos demonstrating DBT (submitted to certification body), and formal training in mindfulness. After training, passing a written exam is required for full certification.

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Once the certification process has been completed by individual therapists, they are listed in a searchable database on the website at <https://dbt-lbc.org/index.php?page=101144>

Office of Behavioral Health (OBH) -sponsored DBT training program

Completion of an OBH-sponsored DBT training program is another method to achieve training and qualification to provide DBT therapy under Louisiana Medicaid.

Provider agency teams who apply for and enter into an OBH-sponsored DBT training program will complete a training process that will include a minimum of seven days of didactic training and 24 consultation calls, typically over a 9-12 month period. This training program will typically begin with several days of didactic training, followed as soon as possible by DBT service provision to clients with the support of weekly (which may later move to biweekly) consultation with the expert DBT trainer, followed by additional days of didactic training and continuing consultation calls.

OBH-approved DBT qualification

The provider agency team, along with the individual practitioners on that team, will be assessed by the DBT trainer throughout the consultation process. Trainer assessment of practitioner and team competence will require practitioner submission of videotaped sessions for review. The DBT trainer will review videotaped sessions and score competence on the following scales to assess both team and individual practitioner competency in the core DBT components:

1. Coaching Scale;
2. Individual Therapy Scale;
3. Skills Training Group Scale; and
4. Consultation Scale.

To achieve completion of an OBH-approved DBT training program leading to OBH-approved DBT qualification, practitioners who are members of an agency team engaged in an OBH-approved DBT training program must:

1. Complete all didactic, consultative, and videotape submission components of the OBH-approved DBT training program; and

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2. Achieve passing scores on the relevant scales assessing competency.

Upon successful completion, the individual practitioner(s) on the team will receive documentation of completion of an OBH-approved DBT qualification.

An additional option for achieving qualification to provide DBT under Louisiana Medicaid, may be used by practitioner teams who have previously engaged in a non-OBH-sponsored DBT training program by their own arrangement. For practitioner teams who have already completed DBT training, the team may seek OBH-approved DBT qualification by engaging in the steps noted above for “OBH-approved DBT qualification.” To achieve OBH-approved DBT qualification, practitioners who are members of the agency team must:

1. Submit documentation of didactic and consultative components of a completed DBT training program;
2. Complete videotape submission components; and
3. Achieve passing scores on the relevant scales assessing competency.

Upon successful completion, the individual practitioner(s) on the team will receive documentation of completion of an OBH-approved DBT qualification.

Quality Assurance

Outcomes

Measuring the progress and outcomes of treatment is a critical aspect of DBT and is part of the evidence-based model. DBT typically uses a set of standard tools, for both adolescent and adult clients, all of which are open source and accessible to providers at no cost. Standard tools to measure the outcomes of treatment include:

1. **Borderline Symptom List 23 (BSL 23):** self-report measure of symptoms such as affective instability and recurrent suicidal/self-harming behavior;
2. **Difficulties in Emotion Regulation Scale (DERS):** self-report measure of emotion regulation problems; and
3. **Ways of Coping Checklist:** self-report measure of the individual’s application of therapeutic skills to cope with stressful events.

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Outcomes measures must be completed by DBT program clients at minimum pre- and post-treatment, and at least at six-month intervals. If a client is receiving a twelve (12)-month episode of care, it may be beneficial to schedule outcomes measurement at four (4) month intervals to better support progress tracking and treatment adjustments over the course of the episode of care.

Client-level data on outcomes metrics will be documented in the client’s health record, interim measures of progress shall be documented in requests for continued service authorization, and pre/post measures included in documentation such as discharge summaries.

DBT provider teams shall aggregate client outcome data at the program level, and submit de-identified program-level aggregate outcomes data to all contracted MCOs (or their designee) semi-annually.

Model-Specific Documentation Requirements

The DBT model does not prescribe a specific format for progress notes, however, use of the DBT model in therapy can be observed in a client’s record by the presence of specific references in the progress note for each session:

1. Clients complete “Diary Cards” each week to bring to their individual therapy session. Data from client-completed diary cards is documented in the progress note for each session. This data on client symptoms and behaviors is then used to set the agenda for the session;
2. Agenda for the session, including the behavioral targets for the session;
3. In most sessions, reference to a DBT-specific assessment (chains, missing links, behavioral assessment) that is used to determine interventions; and
4. Reference to the intervention (i.e. cognitive modification, skills, contingency management, exposure, problem solving) used in the session, and what the client committed to doing for homework or in the future.

Fidelity

As a team-based model, fidelity to the DBT model is best assessed at the team/program level. A DBT program may demonstrate fidelity to the DBT model through delivery of specific program components, policies, and procedures.

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These include:

1. **Team**

Delivery of the comprehensive DBT model requires a team, preferably with 4-6 clinicians trained and qualified to provide DBT individual therapy, and each qualified clinician carrying a caseload of at least 2-3 clients for DBT individual therapy. A DBT team of two DBT-trained and -qualified clinicians is the minimum to maintain qualification as a DBT program; the status of having only two qualified clinicians on a DBT team shall be considered temporary while the team works to replace team members and coordinate replacement training for new team members, to build back up to a full DBT team;

2. **Training**

All DBT team members providing DBT individual therapy must be trained and qualified to provide DBT; please see “Training” in this section for requirements:

- a. A qualified DBT team may add new team members (based on need for expansion of services, and/or need to replace practitioners due to staff attrition) initially by allowing new DBT team members to begin co-leading skills training group prior to completing DBT didactic training, as long as:
 - i. The primary skills training group co-leader has completed DBT training; and
 - ii. The new team member completes DBT training within 6 months of starting to co-lead DBT skills training groups.
- b. A qualified DBT team may add new team members providing DBT individual therapy after the new team member has completed initial DBT didactic training.

3. **Individual therapy**, delivered weekly by a DBT trained clinician;

4. **DBT skills training groups**, held weekly with two clinician co-leaders;

5. **Peer consultation group** with all team members, held weekly, facilitated by the lead clinician from the DBT team. Consultation group with team members addresses group functioning, planning, and dynamics, in the therapy group; and

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6. Telephonic, therapeutic coaching with 24-hour availability to each client.

Annually following completion of DBT training and qualification, the DBT program will complete a **self-assessment of program fidelity** using an OBH-approved process adapted from the DBT-LBC Program Certification Self-Assessment. The DBT program shall use this self-assessment process to review and if needed revise policies and practices, including implementing a corrective action plan as needed for improved alignment with best practices. The self-assessment, and if applicable the corrective action plan, shall be made available at the request of OBH or LDH-contracted managed care organizations.

Following completion of DBT training and qualification, qualified DBT programs will be **externally-reviewed for DBT program fidelity** on a regular basis, using an OBH-approved process adapted from the DBT-LBC Program Certification Self-Assessment and inclusive of practitioner completion of DBT continuing education. DBT program fidelity reviews will be completed at a frequency of every 2 years following DBT program qualification. Fidelity reviews may be requested at a higher frequency if issues are identified that trigger additional review.

Limitations/Exclusions

Limitations and exclusions noted in Section 2.3 -Outpatient Therapy by Licensed Practitioners of this manual chapter apply.

Billing

A DBT practitioner may receive reimbursement for the DBT service, when delivering DBT as part of a DBT team that is:

1. Trained and qualified to deliver DBT as described in the “Training” section, demonstrated by either:
 - a. Certification from the DBT-Linehan Board of Certification (DBT-LBC);
 - b. OBH-approved DBT qualification; or
 - c. Engaged consistently and in good standing (as documented in writing by the OBH-sponsored training organization) in an OBH-sponsored DBT training program that will lead to an OBH-approved DBT qualification, following the agency and practitioner’s completion of the initial didactic

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training sessions, while under consultation with an OBH-approved DBT trainer.

2. Following initial qualification to deliver DBT, the team also must complete periodic fidelity reviews; please refer to the “Fidelity” section;
3. Only direct staff face-to-face time with the individual or family may be billed. DBT is a face-to-face intervention with the individual present. Telehealth delivery is allowed if it includes synchronous, interactive, real-time electronic communication comprising both audio and visual elements. Services provided using telehealth must be identified on claims submission by appending the modifier “95” to the applicable procedure code and indicating the correct place of service, either POS 02 (other than home) or 10 (home). Both the correct POS and the 95 modifier must be present on the claim to receive reimbursement;
4. The DBT model is delivered in three (3) modalities:
 - a. Individual therapy;
 - b. DBT skills training group sessions; and
 - c. Therapeutic coaching (24-hour availability), not billed.
5. The group therapy session must be co-led by two (2) DBT practitioners, and must be delivered for a minimum of 90 minutes; in standard practice the DBT skills training group typically has a duration of 120-150 minutes;
6. For DBT skills training groups which are co-led by two practitioners, one practitioner submits the group therapy claim for a client, with progress notes to be co-signed by both of the group co-leaders. All standard record-keeping requirements must be met, including recording start and end time of service. The co-leader of the DBT skills training group who does not submit the claim, may not have completed the DBT qualification, but must complete initial DBT didactic training within six (6) months of beginning to co-lead DBT skills training groups; and
7. LMSWs, PLPCs and PLMFTs may not directly bill for services provided to a Medicaid enrollee. LMSWs, PLPCs and PLMFTs W may be the rendering

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provider on a claim when in accordance with Title 46 and their individual practice act.

CSOC WRAPAROUND MODEL

The Coordinated System of Care (CSoC) is an approach designed for Medicaid members, between 5 and 20 years of age, who have a severe emotional disturbance (SED) or a serious mental illness (SMI), and who are in or at risk of an out-of-home placement. The CSoC utilizes the Wraparound model which is guided by the following system of care (SOC) values and principles:

1. Family driven;
2. Youth guided;
3. Culturally and linguistically competent;
4. Home and community based;
5. Strength based;
6. Individualized;
7. Integrated across systems, bringing agencies, schools and providers together to work with families;
8. Connected to natural helping networks;
9. Data driven and outcome oriented; and
10. Unconditional care.

The Wraparound model is fully consistent with the SOC framework. Wraparound’s philosophy of care begins from the principle of “voice and choice”, which stipulates that the perspectives of the family, including the child or youth, must be given primary importance during all phases and activities of Wraparound. The values associated with Wraparound further require that the planning process itself, as well as the services and supports provided, should be individualized, family-driven, culturally competent, and community-based. Additionally, the Wraparound process should increase the “natural support” available to a family by strengthening interpersonal relationships and utilizing other resources that are available in the family’s network of social and community relationships. Finally, the Wraparound process should be “strengths-based”, including activities that purposefully help the child and family to recognize, utilize and build talents, assets and positive capacities.

In CSoC, Wraparound agencies (WAAs) serve as the locus for access, accountability, service coordination, and utilization management functions. There is one WAA in each region of the State.

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The WAA is responsible for facilitating the Wraparound process, developing individualized plans of care (POC) that cross agencies, and assigning the Wraparound Facilitator (WF) to coordinate care. The WF works with the child/youth and their parent/primary caregiver to build a team, which includes formal provider(s), system partners currently working with the family, as well as the family’s natural/informal supports. Once enrolled in CSOC, children/youth and families have access to parent support/training and youth support/training specialists, who are employed by the Family Support Organization (FSO).

The WF is responsible for assisting the family in building a team and facilitating the child and family team (CFT) meeting process with support and coaching from a WF supervisor/coach. The WF acts as a bridge between the CSOC contractor and families, and assists the family in building a CFT.

The CFT works with the family to create **one** cohesive plan to coordinate care and address identified needs. The WF will work with children and youth, their families, providers, regional agency staff, courts, child welfare agencies, schools, community organizations, and the FSO to coordinate care planning and access to comprehensive services and supports. Service coordination by the WAA, in collaboration with the FSO, will be guided by the four phase Wraparound process, which is defined by the standards and principles established by the National Wraparound Initiative (NWI). (See Appendix A of this manual chapter for links to the NWI website and information on the ten principles of wraparound).

Eligibility Criteria/Process

In order to be eligible, the child or youth must also have functional needs as demonstrated by the Child and Adolescent Needs and Strengths (CANS) comprehensive assessment. Children identified as meeting the criteria for CSOC, as determined by the CANS, may include:

1. Children and youth, 5-20 years of age with significant behavioral health (BH) challenges or co-occurring disorders documented in the Individualized Behavioral Health Assessment (IBHA). This includes youth primarily demonstrating externalizing behaviors, such as conduct disorder, delinquent, antisocial or illegal behavior or acts, substance-related disorders and attention deficit hyperactivity disorder issues that lead to costly, and oftentimes, ineffective out-of-home services or excessive use of other therapeutic supports and services. Co-occurring disorders (COD) primarily refer to the presence of mental health and substance-related disorders. Children and youth with COD have one or more substance-related disorder(s), as well as one or more mental health disorder(s);
2. For children with BH disorders and developmental disabilities, if the child has a SED and otherwise meets criteria for CSOC, they are eligible for services within CSOC for their SED;

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3. Individuals with an Office of Citizens with Developmental Disabilities (OCDD) statement of approval who receive waiver supports or state funded supports via the local governing entity (LGE), these services will continue to be coordinated by the identified support coordinator. Other services to meet the youth’s needs related to their intellectual/developmental disability will be coordinated by the appropriate entity based on the youth’s enrollment status and identification of agency responsibility (i.e., Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services will be coordinated via the fee –for – service (FFS) process if youth is not enrolled in a health plan or by the health plan if they are; school services will be coordinated by the school); and

NOTE: Children/youth cannot be enrolled in more than one home and community based services (HCBS) 1915(c) waiver at a time. However, a child/youth can be enrolled in a 1915 (c) and the 1915 (b)(3) waiver programs authorized under section 1915 (c) and 1915 (b) of the Social Security Act.

4. Children in an out-of-home placement, or at risk of being placed out of home including:
- a. Addiction facilities;
 - b. Detention;
 - c. Homeless (as identified by the Department of Education (DOE));
 - d. Intellectual/developmental disabilities facilities;
 - e. Non-medical group home;
 - f. Psychiatric hospitals;
 - g. Psychiatric residential treatment facilities;
 - h. Secure care facilities;
 - i. Therapeutic foster care; and
 - j. Therapeutic group home.

In addition to the child/youth receiving services, parents/primary caregivers must participate in the CFT process. Other adult caregivers, siblings, extended family members, and other natural supports, identified by the youth and family, may also participate in the CFT process. In addition, representatives from other agencies in which the child/family is involved, such as child welfare or

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juvenile services, are also typically involved to add their perspectives to the development of the POC. Families will be encouraged to provide their own perspectives on their strengths and needs.

In order to determine eligibility, the CSOC contractor will conduct a brief CANS comprehensive assessment over the phone with the child or parent. If the brief assessment indicates that the child is (presumed) eligible for CSOC, the CSOC contractor will send referrals and initial 30-day authorization to the appropriate WAA electronically upon completion of the telephonic interview.

The CSOC contractor will authorize the WAA to arrange community services necessary to support the child and family for up to 30 days while establishing the CFT and beginning the Wraparound planning process.

An approved licensed BH practitioner will sign off on any treatment to ensure that services by unlicensed individuals are medically necessary.

The WAA will work with the family to gain access to federal funding when available (i.e., help them complete a Medicaid application). The WAA shall initiate the CFT process immediately upon receipt of the referral by the CSOC contractor.

The following must be completed within 30 days of the start of WAA involvement:

1. CANS comprehensive assessment and IBHA;
2. Individualized POC – A copy of the initial assessment and individualized POC developed by the CFT must be completed within 45 days of the start of WAA involvement. The individualized POC must be developed with adherence to NWI standards and treatment planning requirements consistent with 42 CFR 438.208(c)(3); and
3. CFT meeting documentation – The initial CFT meeting must be held within 45 days of the start of WAA involvement. Participation in the CFT process is documented through the signatures of the child/youth, parents or caregivers of the child/youth and other CFT members on the POC.

The CSOC contractor may require proof that these requirements have been met through periodic audits of select cases or providers.

CSOC Level of Care Process

Level of care (LOC) is determined using the CANS comprehensive assessment in conjunction with a bio-psychosocial assessment, the IBHA. The CANS comprehensive assessment is completed based on an interview with the child and parent(s) and additional supporting information. The

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CANS assessment addresses the following domains: life domain functioning, youth strengths, acculturation, caregiver strengths and needs, youth behavioral/emotional needs, and youth risk behaviors. Goal development is directly related to the CANS assessment. The initial CANS comprehensive assessment is completed by a CANS certified licensed mental health professional (LMHP) after the member/beneficiary scores positive on the Brief CANS and is referred to the WAA for services. (See Appendix D of this manual chapter for LMHP definition). The initial comprehensive CANS must be completed within 30 days of the referral and is used to develop the initial POC.

CANS comprehensive assessment must be completed on each child/youth enrolled in CSOC at a minimum of every six (6) months, or more frequently if conditions warrant re-evaluation. These conditions would include evidence that the child/youth has had a significant change in risk factors, an extended need for increased services has been identified, or a decision regarding changes in LOC is required. Reassessment must be completed by a CANS certified LMHP.

Re-evaluation must take into account any clinical evidence of therapeutic clinical goals that must be met before the individual can transition to a less intensive LOC and clinical evidence of symptom improvement.

Goals are established based upon the child's/youth's needs. Interventions for goals are built upon the child's/youth's identified strengths. CFT identifies goals and interventions based upon the CANS comprehensive assessment as well as the child/youth, parent(s) or primary caregiver(s) and other team members input. POC goals identified as being the most pertinent or pressing by the child/youth and parents/caregivers of the child/youth are given preference.

The Wraparound Model

The NWI website (see Appendix A) is the source of the following information. Wraparound is an intensive, creative and individualized care planning and management process. Wraparound is not a treatment, per se. Instead, Wraparound is a care coordination approach that fundamentally changes the way in which individualized care is planned and managed across systems. The Wraparound process aims to achieve positive outcomes by providing a structured, creative, and individualized team planning process that, compared to traditional treatment planning, results in plans that are more effective and more relevant to the child and family. Additionally, Wraparound plans are more holistic than traditional care plans because they address the needs of the youth within the context of the broader family unit and are also designed to address a range of life areas. Through the team-based planning and implementation process, Wraparound also aims to develop the problem-solving skills, coping skills and self-efficacy of the young people and their family members. Finally, there is an emphasis on integrating the youth into the community and building the family's social support network.

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The Wraparound process is facilitated by a WF, who works with the child/youth and their parent/primary caregiver to create a CFT. The child/youth and the family comprise the core of the CFT members, joined by parent and youth support/training staff from the FSO, providers involved in the care of the family, representatives of agencies with which the family is involved and natural supports chosen by the family. The CFT is the primary point of responsibility for coordinating the many services and supports involved, with the family and youth ultimately driving the process. The Wraparound process involves four phases over which responsibility for care coordination increasingly shifts from the Wraparound facilitator and the CFT, to the family.

The goals of the Wraparound process are to:

1. Meet the behavioral health needs prioritized by the youth and family;
2. Improve the family’s ability and confidence to manage their own services and supports;
3. Develop and strengthen the family’s natural social support system over time; and
4. Integrate the work of all child-serving systems and natural supports into one streamlined plan to address the child’s behavioral health needs in order to restore the child to a developmentally appropriate level of functioning.

The CFT will identify specific goals to enhance the functioning of the child, and recommended services that will be consistent with the medical necessity criteria of the CSOC contractor.

Phase One: Engagement and Team Preparation

During this phase, the WF is responsible for establishing the groundwork of trust and shared vision among the family and Wraparound team members. The WF orients the youth and family to the Wraparound process; stabilizes immediate crisis; explores the strengths, needs, vision and culture of the family; begins to identify potential team members, including formal and informal supports; engages potential team members, with the consent of the family; and begins to prepare for the first CFT meeting. (*Source: Phases and Activities of the Wraparound Process: Building Agreement about a Practice Model.* (See Appendix A of this manual chapter).

Key Activities During Phase One: Engagement and Team Preparation

1. Upon referral to the WAA, the CSOC contractor will authorize completion of CANS comprehensive assessment and IBHA to be conducted by a CANS certified licensed mental health provider (LMHP), to confirm the clinical eligibility of the youth/child. The findings will be sent to the WF to assist the CFT in the Wraparound planning process;

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2. The WF shall work closely with the FSO to integrate the provision of supports from parent and youth support/trainers. It is expected that personnel from the FSO will have ongoing active involvement on the CFT, unless the family chooses not to have them involved or the CFT in consultation, as needed, with the physician overseeing the care determines, FSO involvement to be clinically contra-indicated. It is expected that parent support and training (PST) and youth support and training (YST) will be a key component of the array of services and supports included in the POC;
3. During the initial contact with the youth and family, the WF ensures the delivery of the CSOC brochure describing the CSOC services, free choice of providers and how to report abuse and neglect. Each CSOC child/youth will be a member of the CSOC contractor and will be provided a member handbook. In the member handbook, the member's rights and responsibilities are identified. The WF will also ensure that the family is offered the choice of either institutional or HCBS waiver services, using the Freedom of Choice form;
4. During preliminary discussions of treatment, the child/youth and their parents or caregivers are informed by the WF of the array of services that may be accessed through the CSOC. The array of services available to the family includes waiver-specific services and also includes services available in the SOC outside of the SED waiver. Examples of such services would be traditional behavioral health services, such as medication management and individual therapy provided in the home. Non-traditional community-based services, such as PST and YST, as well as psychosocial treatment group, would also be available. Naturally occurring supports outside of the behavioral health system are also utilized to support the family. Formalized services are not incorporated to take the place of existing or identified natural supports;
5. During the initial meetings the Wraparound facilitator will work closely with the child/youth and family/caregiver to determine membership of the CFT;
6. The WF shall work closely with the child welfare, juvenile justice and local education agencies (LEAs) to integrate care management responsibilities. It is expected that personnel from all the child-serving State agencies, the juvenile justice system and LEAs will have active involvement on the CFT unless clinically contra-indicated;
7. With the child/youth, family and other identified team members, including information from the CANS assessment/IBHA, the WF will conduct a strengths, needs and cultural discovery, to assist the family in identifying a family vision and

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produce a narrative ‘family story’ document, to share with the youth, family and other team members; and

8. The WF is responsible for coordinating with the youth, family and other team members to schedule and prepare for the first CFT.

Phase Two: Initial Plan Development

During Phase Two, trust and mutual respect are built while the team creates an initial POC. With the CFT, the WF assists in determining the ground rules of the meetings; eliciting and documenting strengths from all team members; creating the team mission; describing and prioritizing needs/goals; determining plan objectives and indicators for each objective; selecting strategies that utilize both formal and informal supports; assigning action steps; assessing potential risks; and development of a crisis plan and an initial POC. *Source: Phases and Activities of the Wraparound Process: Building Agreement about a Practice Model.* (See Appendix A of this manual chapter).

Key Activities during Phase Two: Initial Plan Development

1. The child/youth and parents or caregivers of the child/youth must be involved in the development of the POC. In addition, behavioral health providers, representatives of agencies legally responsible for the care or custody of the child and other individuals are strongly encouraged to participate in the development of the POC;
2. Participation in the CFT process is documented through the signatures of the child/youth, parents or caregivers of the child/youth, and other CFT members on the POC. The CSOC contractor must operate from one integrated POC. This reinforces the Wraparound process and results in the POC encompassing all services that may be accessed through the CSOC contractor;
3. The WF is responsible for communicating with the child/youth’s primary care physician (PCP). The WF must document attempts to communicate and coordinate with the child’s PCP in the development of the individualized POC. If the child’s PCP wishes to take part in the development of the individualized POC, then the WF must ensure that the PCP is involved to the extent they desire. If the PCP chooses not to participate in the care planning process, then the WF must initiate communication with the PCP and ensure that a copy of the individualized POC is sent to the PCP. **Note:** BH treatment must be ordered and overseen by a physician or other LMHP to comply with other federal requirements;
4. The POC is developed based upon the CANS comprehensive assessment and identified goals, as determined by the CFT. The child/youth and parents or

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caregivers of the child/youth have the primary role of identifying appropriate goals, strengths, needs and the development of a risk assessment and crisis/safety plan. Input of all members of the CFT is used to identify the appropriate frequency and duration of CSOC services (including relevant clinical and agency service information provided by providers and other agency members of the CFT, as well as natural supports that are built into the POC to assist the child/youth in meeting their goals;

5. The WF plays a role in this process by facilitating POC development through documentation of the decisions made by the CFT, facilitating the overall meeting and ensuring that all members of the team have the opportunity to participate. Should needs or circumstances change, the child/youth and parents or caregivers of the child/youth have the ability to request a meeting of their CFT at any time;
6. The WF will provide adequate notice of the CFT meetings to all of the CFT members. To ensure the planning process is timely, WAAs will comply with the basic service delivery standards as outlined in the CSOC contractor and WAA contracts. The WF is responsible for writing the POC, based upon the determinations made by the CFT;
7. Once developed, the WF will ensure POCs are entered into the CSOC contractor's database and electronic health record, ensuring that compliance with the Health Insurance and Portability Act (HIPAA) and Federal Educational Right to Privacy Act (FERPA) standards are maintained. The WF will submit the POC to the CSOC contractor for review prior to the end of the initial 45-day authorization period;
8. The CSOC contractor reviews the POC for consistency with the child/youth and family's strengths and needs (as identified by the CANS comprehensive assessment, IBHA, broader assessment and the POC and utilization guidelines. If the POC meets these criteria, the CSOC contractor provides authorization for a period of up to 180 days. On-going authorizations provided by the CSOC contractor will be for up to 180-day periods for most children/youth;

NOTE: Authorizations may exceed 180 days for some children/youth, as determined by medical and social necessity for the service.

9. If the POC appears to be inconsistent with assessed strengths and needs and the utilization guidelines for the desired services, or if it exceeds the cost of care limitations, the CSOC contractor and the WAA WF discuss the child/youth/family strengths and needs to determine a recommendation for further discussion with the CFT;

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10. An approved licensed BH practitioner must approve any treatment on the POC to ensure that services by unlicensed individuals are medically necessary;
11. Each POC is required to contain a crisis and safety plan. Crisis plans are developed in conjunction with the POC during the CFT meeting, based upon the individualized preferences of the child/youth and parents or caregivers of the child/youth. As with the POC itself, the child/youth and parents or caregivers of the child/youth may choose to revise the crisis plan at any time they feel it is necessary. Each crisis plan is individualized to the child/youth. A potential crisis (risk) and appropriate interventions (strategies to mitigate risk) are specific to the child/youth and identified by the CFT; and
12. The crisis plan includes action steps, as a backup plan, if the crisis cannot be averted. The action steps are developed through the Wraparound process by the CFT and incorporated in the crisis plan. The action steps may involve contacting natural supports, calling a crisis phone line or contacting the WF, etc. The CSoC contractor is required to provide 24 hours a day/365 days a year crisis response that is readily accessible to children/youth and their parents or caregivers. A required component of the crisis plan is the contact information for those involved at all levels of intervention during the crisis. Families are provided a copy of the crisis plan as an attachment to their POC in order to have access to the identified information should a crisis occur.

Phase Three: Plan Implementation

During Phase III, the initial POC is implemented, progress and success are continually reviewed, and changes are made to the plan based on observations and data, then implemented. It is the role of the WF to maintain team cohesion and mutual respect. The activities of this phase are repeated until the identified team mission is achieved and formal Wraparound is no longer needed. The WF is responsible for ensuring that there is an implemented action step for each strategy on the plan; tracking progress on action steps, with the CFT evaluating success of the strategies, celebrating successes; considering new strategies, when needed; maintaining awareness of team members 'buy-in'; addressing issues of team cohesion and trust; completing necessary documentation of the CFT process. *Source: Phases and Activities of the Wraparound Process: Building Agreement about a Practice Model.* (See Appendix A of this manual chapter).

Key activities during Phase Three: Plan Implementation

1. The WF is responsible for monitoring and follow-up activities, including intensive care coordination and reviewing the POC with the CFT, at minimum, monthly, (more frequently, if needed) to update the POC to reflect the changing needs of the child/youth. The WF and CFT reviews: 1) whether services are being provided in

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accordance with the POC, 2) whether the services in the POC are adequate, and 3) whether there are changes in needs or status of the individual and, if so, adjusting the POC as necessary. The CFT is the primary point of responsibility for coordinating the many services and supports with which the youth and family are involved, and the family and youth ultimately drive the goals of the CFT. Over time, the responsibility for care coordination increasingly shifts from the WF and the CFT to the family; and

2. A CFT meeting can be convened at any time in which needs or circumstances have changed or the child/youth and parents or caregivers of the child/youth feel it is warranted, or the needs of the child/youth require the CFT to meet on a more frequent basis to best coordinate care.

The WF is responsible for the following:

1. Supporting the action steps of the POC by checking in and following up with CFT members, educating providers and other system and community representatives about the Wraparound process, as needed, and identifying and obtaining necessary resources;
2. Monitoring progress on the action steps of the POC by tracking information about the timeliness of completion of responsibilities assigned to each team member, fidelity to the POC and completion of planned interventions;
3. Guiding the CFT in evaluating whether selected strategies are helping meet the youth's and family's needs;
4. Encouraging the team to acknowledge and celebrate success when progress has been made, when outcomes or indicators have been achieved or when positive events or achievements occur;
5. Supporting the CFT to determine when strategies for meeting needs are not working or when new needs should be prioritized, and guiding the CFT in a process of considering new strategies and action steps using the process described above for developing the POC;
6. Making use of available information to assess CFT members' satisfaction with and commitment to the CFT process and POC, sharing this information with the CFT, as appropriate, and welcoming and orienting new CFT members who may be added as the process unfolds;

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7. Helping to maintain CFT cohesiveness and satisfaction, supporting fidelity to Wraparound principles and activities and guiding the CFT in understanding and managing any disagreements, conflicts or dissatisfactions that may arise; and
8. Maintaining/updating the POC document including results of reviews of progress, successes and changes to the CFT and POC over time and maintaining/distributing copies of the POC to CFT members.

Phase Four: Transition

During this phase, plans are made for a purposeful transition out of formal Wraparound to a mix of formal and natural supports in the community. The focus on transition is continual during all of the Wraparound process and the preparation for transition is apparent even during the initial engagement phase and activities. The WF is responsible for assisting the CFT in creating a transition plan; creating a post-transition crisis management plan; modifying the Wraparound process to reflect transition; documenting the teams work, celebrating success and checking in with the family after discharge. *Source: Phases and Activities of the Wraparound Process: Building Agreement about a Practice Model.* (See Appendix A).

Key activities of Phase Four: Transition

The final phase of activity centers on the transition from the CFT to natural supports. During this phase, the Wraparound facilitator and CFT focus on planning for a purposeful transition out of formal Wraparound to a mix of formal and natural supports in the community (and, if appropriate, to services and supports in the adult system).

The focus on transition is continual during the Wraparound process, and the preparation for transition is apparent even during the initial engagement activities. However, this is the primary focus of the transition phase of the Wraparound process.

Wraparound Agency Requirements

There is one Wraparound Agency (WAA) for each of the Act 1225 regions. WAAs were selected by community teams which included local state agency leaders and other members of the community. The WAA is responsible for conducting the Wraparound process for eligible youth in their region.

WAA Qualification Requirements

1. Arranges for and maintains documentation that all persons, prior to employment, pass criminal background checks and a search of the U.S. Department of Justice National Sex Offender Registry. If the results of any criminal background check

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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 checks must be performed as required by La. R.S. 40:1203.1 *et seq.*, and in accordance with La. R.S. 15:587 *et seq.*;

2. 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;
3. 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 Louisiana Department of Health (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>;
4. 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

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provider shall maintain the results of completed searches in the LEIE and LDH State Adverse Action databases in the individual’s personnel record;

5. Establishes and maintains written policies and procedures inclusive of drug testing staff to ensure an alcohol and drug-free workplace and a workforce free of substance use;
6. Maintains documentation that all direct care staff, who are required to complete First Aid, cardiopulmonary resuscitation (CPR) and seizure assessment training, complete American Heart Association (AHA) recognized training within 90 days of hire, which shall be renewed within a time period recommended by the AHA;
7. Ensure and maintains documentation that all unlicensed persons employed by the organization complete training in a recognized crisis intervention curriculum prior to handling or managing crisis calls, which shall be updated annually; and
8. Maintains documentation of verification of staff meeting educational and professional requirements, as well as completion of required trainings for all staff.

WAA Certification and Credentialing Requirements

In order to develop CSOC POCs through CFT activities and access funding through the administrative portion of the CSOC contractor, each WAA must be credentialed and certified by the CSOC contractor.

In order to maintain CSOC certification, all WAA staff must meet the current provider qualifications as defined in the most recent Behavioral Health Services manual chapter of the Medicaid Services Manual. The WAA must ensure that all WF supervisors and facilitators are participating in ongoing Wraparound training that is in alignment with the NWI’s fidelity standards and approved by OBH. In addition, all Wraparound supervisors must complete all required trainings and conduct face-to-face observations of staff they supervise in CFTs and other meetings on an on-going basis as defined in the WAA Certification application. In addition, the certification process includes documenting that individual WAA staff members have completed training, as described in the section below.

WAA Staff Qualification Requirements

1. 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;

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2. 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;
3. Staff must not have a finding on the Louisiana State Adverse Action List;
4. Pass drug screening tests as required by WAA provider's policies and procedures; and
5. Complete AHA recognized First Aid, CPR and seizure assessment training. (Note: psychiatrists, APRNs/PAs, registered nurses (RNs) and licensed practical nurses (LPNs) are exempt from this training).

Staffing Requirements and Qualifications

In order to maintain WAA certification and to ensure compliance with Wraparound fidelity requirements, WAA staff must meet the following educational and experience requirements, as specified below. The WAA must maintain documentation of verification of completion of required trainings for all staff.

Staffing Guidelines for WAAs

Positions/functions include an executive director or program director, business manager, Wraparound facilitators with a caseload of no more than ten families (unless approved by OBH), Wraparound supervisors/coaches with a recommended ratio of one supervisor/coach per eight WF (unless approved by OBH), quality improvement/data director, community resource specialist, administrative assistants and 1.0 FTE licensed mental health professional clinical director, quality improvement/data director.

Wraparound Facilitator (WF)

The WF must meet the following requirements:

1. Bachelor's-level degree in a human services field or bachelor's-level degree in any field, with a minimum of two (2) years of full-time experience working in relevant family, children/youth or community service capacity. Relevant experience shall include working with the target population; experience in navigating any of the child/family-serving systems; and experience advocating for family members who are involved with behavioral health systems. Relevant alternative experience may substitute for the bachelor's-level degree requirement in individual cases, subject to approval by LDH; and
2. Completion of the required training for WFs.

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Certified WAAs must also employ staff to supervise and coach the WFs.

Requirements include the following:

1. Master’s-level or higher graduate degree in a human services field (see Appendix B of this manual chapter);
2. Master’s level or higher graduate degree in any field, with a minimum of three years of full-time experience working in relevant family, children/youth or community service capacity. Relevant experience shall include working with the target population; experience in navigating any of the child/family-serving systems; and experience advocating for family members who are involved with behavioral health systems. Relevant alternative experience may substitute for the degree requirement in individual cases, subject to approval by LDH;
3. Completion of the required training for WF supervisors/coaches;
4. If the supervisor/coach also functions, in part, as a Wraparound facilitator, they must also meet the requirements for a Wraparound facilitator described above;
5. The WF supervisor/coach must provide regular supervision and coaching to WF service delivery staff, including completion of all supervisor and coaching requirements for high fidelity Wraparound; and
6. The WF supervisor/coach must have expertise, knowledge and skills in the Wraparound model and possess the ability to teach and develop those skills in the Wraparound facilitator. Previous wraparound experience is preferred. A Wraparound supervisor/coach must have a high degree of cultural awareness and the ability to engage families from different cultures, and backgrounds. A preferred supervisor/coach characteristic is an understanding of, and experience with, different systems, including schools, behavioral health, child welfare, juvenile justice, health and others. The WF supervisor/coach must oversee the work of the WF on an ongoing basis.

Core Training Requirements for the Wraparound Supervisors/Coaches and Facilitators

All Wraparound direct care staff, including but not limited to supervisors/coaches and facilitators, are required to participate in OBH approved trainings described below.

Introduction to Wraparound (3-day)

This is the first training of the series for frontline Wraparound practitioners, supervisors/coaches, and directors who may participate in a child and family team process. Through attendance at this training, participants will be able to:

1. Gain an understanding of the critical components of the Wraparound process in order to provide high fidelity Wraparound practice; and
2. Practice the steps of the process to include eliciting the family story from multiple perspectives, reframing the family story from a strengths perspective, identifying functional strengths, developing vision statements, team missions, identifying needs, establishing outcomes, brainstorming strategies, and creating a plan of care and crisis plan that represents the work of the team and learn basic facilitation skills for running a CFT meeting.

Wraparound supervisors/coaches and facilitators must participate in the Introduction to Wraparound within the first 60 days of employment and repeat the training at least once during their first two years of practice.

Child and Adolescent Needs and Strengths (CANS) Training

Within the first 90 days of employment Wraparound supervisors/coaches and facilitators must be trained on the CANS for Louisiana Comprehensive Multisystem assessment. All supervisors/coaches, LMHPs and facilitators must be recertified on an annual basis. See Appendix A of this manual chapter for a link to the PRAED Foundation’s collaborative training website.

Ongoing Training Activities for Wraparound Facilitators and Supervisors/Coaches

Each staff member must participate in training activities to address new information and deficiencies identified by their supervisor.

Additional Training Requirements

Any additional training and professional development initiatives as required by the waiver and/or required by OBH to support fidelity to Wraparound practice.

Observation of Wraparound Facilitators by Supervisor/Coach

Supervisors/coaches are required to observe Wraparound facilitators as follows:

1. Three observations within the first six months of hire (two CFT meetings; One – supervisor’s choice); and
2. Minimum of one CFT observation every six months, after six months of hire.

Additional Training Requirements for Wraparound Supervisors/Coaches

An ‘Introduction to Coaching’ training which must be approved by OBH, is mandatory for local supervisors/coaches in the WAA. Through attendance at this training, participants will be able to:

1. Identify the skills necessary to support high-fidelity Wraparound practices;
2. Develop an increased understanding of the roles and responsibilities of the local supervisor/coach; and
3. Develop skills to support Wraparound facilitators in high-fidelity Wraparound practices.

Allowed Provider Types

Wraparound process is not considered a service; therefore, it is included in the administrative rate.

Limitations and Exclusions

All coordination of care activities must protect each member’s privacy in accordance with the privacy requirements at 45 CFR, parts 160 and 164, subparts A and E, to the extent that they are applicable.

Costs associated with planning activities that are the responsibility of other child-serving systems are not eligible for Medicaid reimbursement and will need to be tracked and paid separately. When determining if the meeting time is reimbursable by Medicaid, as opposed to other services, the purpose of the planning meeting is the key differentiating factor.

If the purpose is to coordinate medical and non-medical supports for the ultimate purpose of advancing medical treatment goals (for example, facilitating diversion from an accredited residential treatment facility), then the CFT activities are Medicaid reimbursable. However, if the primary purpose of the planning meeting is to develop a permanency plan for a child welfare placement, CFT activities are not Medicaid reimbursable and must be supported with non-

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Medicaid funds. As a result, close coordination is essential between the WAA WF and the Department of Children and Family Services (DCFS) to align BH services and supports to support and inform the DCFS-developed permanency plans. In addition, consistent with Medicaid managed care rules, CSOC contractor will ensure that all CFTs are aware of and utilize the CSOC contractor’s medical necessity criteria for any BH medical services recommended as part of an individualized POC.

Conflicts of Interest

Because of the inherent conflicts of interest that might arise if WAAs also directly provide the services they manage, WAAs will not act as service providers.

NOTE: This language does not preclude the parent agency of a WAA, from providing regionally-based crisis response services, under a separate behavioral health services provider license, enrolled and credentialed as a separate entity.

Non-Reimbursable Activities

Direct services may not be provided by the CFT members as part of their contractually defined WAA role. The WAA staff may not provide direct services to any child for whom they have assisted in developing the POC. Any CFT members providing direct services outside of their WAA role must ensure that there is no conflict of interest between their direct care activities and their WAA responsibilities. Any direct services would be reimbursed separate from WAA reimbursement, in accordance with CSOC contractor contractual relationships with the provider. Any direct service expense would be reported, along with medical service expenses, in the financial and encounter reporting processes.

The following activities by Wraparound facilitators are not allowable:

1. Activities that are not delivered to a specific enrolled child or youth or the family of that child/youth in support of the child’s/youth’s treatment;
2. Activities that are the responsibility of another State agency and are excluded from Medicaid coverage (such as child welfare permanency planning). The WAA must ensure that only specifically documented coordination and delivery of BH services and supports are reimbursed by the CSOC contractor; and
3. Transportation of the member is not a reimbursable component of WF. The WAA will coordinate with local Medicaid transportation supports, and also help children and families connect with natural supports, to provide needed transportation as part of the CFT process. In addition, the WAA provider may develop other local funds to cover staff and travel costs to provide transportation.

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APPENDIX G-1: Standardized Assessments for Beneficiaries Receiving CPST and PSR

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Standardized Assessments for Beneficiaries Receiving CPST and PSR

All mental health rehabilitation (MHR) providers are required to implement the statewide use of the Child Adolescent Level of Care Utilization System (CALOCUS) and the Level of Care Utilization System (LOCUS) for beneficiaries receiving community psychiatric support and treatment (CPST) and/or psychosocial rehabilitation (PSR) between the ages of 6 through 20 years of age. The CALOCUS is not required for beneficiaries under the age of 6 years of age. For beneficiaries 21 years of age and older, there are no changes in the administration of the LOCUS for this age group.

Beneficiaries 6-18 Years of Age

Beneficiaries receiving CPST and/or PSR, ages 6 through 18 years of age, must be assessed using the CALOCUS.

Beneficiaries 19-20 Years of Age

Beneficiaries receiving CPST and/or PSR, ages 19 through 20 years of age, must be assessed using the LOCUS.

Beneficiaries Enrolled in the Coordinated System of Care

For beneficiaries who are enrolled in the Coordinated System of Care (CSoC) and are receiving CPST and PSR, MHR providers are only required to complete the CALOCUS/LOCUS at discharge from the CSoC program. The CSoC contractor will include the discharge rating in the CSoC packet submitted to the beneficiary’s managed care organization (MCO). The next rating will be due six months following this rating. If the discharge packet does not include a CALOCUS/LOCUS discharge rating, the MHR provider will be required to conduct a rating within 30 calendar days following the transition back to the beneficiary’s MCO for CPST and PSR services to continue.

The following applies to beneficiaries between the ages of 6 through 20 years of age enrolled in an MCO.

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APPENDIX G-1: Standardized Assessments for Beneficiaries Receiving CPST and PSR

Conducting the CALOCUS/LOCUS Rating

The assessment and rating must be conducted face-to-face with the member and shall be completed with the involvement of the primary caregiver as well as with other natural supports if necessary. The assessment shall be conducted in a culturally and linguistically competent manner. The rating shall be part of a full psychosocial/psychiatric assessment.

Documentation

MHR providers must use assessment forms that collect all data elements necessary to rate the CALOCUS. The LOCUS assessment form currently being used for beneficiaries 21 years of age and older must be used for beneficiaries 19-20 years of age. Providers must also submit CALOCUS/LOCUS ratings on a form that includes the rating in each dimension, the criteria to support the rating, independent criteria, the composite score, the level of care, a section to document notes, a signature line with credentials, and a rating date. A sample rating form is on page 48 of the CALOCUS manual.

Frequency of Use

A CALOCUS/LOCUS rating must be completed and submitted for all beneficiaries prior to receiving CPST and/or PSR as part of the initial comprehensive assessment and every 180 days thereafter until discharge. The last CALOCUS/LOCUS rating shall be administered at discharge and submitted to the beneficiary’s MCO. In the event a beneficiary is not available to conduct a final rating upon discharge, the provider should make a note in the beneficiary’s record and notify the beneficiary’s MCO or the CSoC contractor. For the discharge rating, a comprehensive assessment is not required. The rating should be part of the beneficiary’s discharge summary and may be completed during an individual therapy session, or while delivering community psychiatric support and treatment. A psychiatric diagnostic evaluation (90791) is limited to one every six months or two per year. Therefore, it should not be used for the discharge rating.

The MCO may request a reassessment when a beneficiary transfers from one MHR provider to another MHR provider if there has been a clinical change that may necessitate an updated rating or if there is a gap in services within six months and an updated rating is needed. Upon such a transfer, the MCO will make available to the new provider the previous CALOCUS/LOCUS data if the previous provider does not have the information. There is an exception for beneficiaries enrolled with Louisiana Healthcare Connections (LHCC). The new provider who is unable to obtain the

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records from the previous provider should conduct an assessment and CALCOUS/LOCUS rating instead of requesting the records from LHCC.

Staff Level

The CALOCUS/LOCUS must be conducted and rated by a physician or licensed mental health practitioner (LMHP) who has successfully completed the required training. An LMHP is an individual who is licensed in the state of Louisiana to diagnose and treat mental illness or substance use, acting within the scope of all applicable state laws and their professional license. An LMHP includes the following individuals licensed to practice independently:

1. Medical psychologist;
2. Licensed psychologist;
3. Licensed clinical social worker (LCSW);
4. Licensed professional counselor (LPC);
5. Licensed marriage and family therapist (LMFT);
6. Licensed addiction counselor (LAC); and
7. Advanced practice registered nurse (APRN).

APRNs must be nurse practitioner specialists in adult psychiatric and mental health as well as in family psychiatric and mental health or they must be certified nurse specialists in psychosocial, gerontological psychiatric mental health, adult psychiatric and mental health, and child-adolescent mental health. They may practice to the extent that services are within the APRN's scope of practice.

Training

Physicians and LMHP staff assessing beneficiaries using the CALOCUS/LOCUS must complete training prior to conducting their first rating. The MCOs and the CSoC contractor must require

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APPENDIX G-1: Standardized Assessments for Beneficiaries Receiving CPST and PSR

physicians and LMHP staff conducting CALOCUS/LOCUS ratings to repeat the training if ratings are inconsistent with the clinical information submitted with the rating. MCOs and the CSoc contractor shall ensure MHR providers have access to training for all physicians and LMHP staff

MCO Use of CALOCUS/LOCUS Data

CALOCUS/LOCUS data including the rating for each dimension, the final score and level of care, psychosocial and psychiatric assessments, treatment history, other standardized assessment tools, and treatment plans shall be used to determine eligibility, frequency and duration for CPST and/or PSR. Other useful sources of information that a provider may submit include data from school, other mental health or substance use providers, etc.

A beneficiary’s final score/level of care, or a rating in one or more dimensions on the CALOCUS/LOCUS, should not be used as the only data element to determine who may be eligible or should continue to receive CPST and/or PSR. A beneficiary’s rating shall also not be used as the only factor to determine a service authorization, using a pre-established set of services and number of units for a duration of time, based on the results of a beneficiary’s CALOCUS/LOCUS rating.

Exceptions

Beneficiaries who receive Multi-Systemic Therapy, Homebuilders, Functional Family Therapy and Functional Family Therapy-Child Welfare are not required to be assessed using the CALOCUS.

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APPENDIX G-2: Employment Supports for Beneficiaries Receiving CPST and PSR

Employment Supports for Beneficiaries Receiving Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR)

All mental health rehabilitation (MHR) providers are encouraged to assess the need and implement appropriate services to support a beneficiary’s employment goals within the context of community psychiatric support and treatment (CPST) and psychosocial rehabilitation (PSR) as appropriate for the beneficiaries they serve. CPST and PSR could be utilized to prepare for or in a workplace environment with a focus on helping a person overcome/address psychiatric symptoms or to develop and/or build a skill set that interfere with seeking, obtaining, or maintaining employment. Medicaid reimbursement for CPST/PSR includes employment supports if the services being provided are focused on illness management and recovery regardless of setting.

The licensed mental health professional (LMHP) should assess the perceived and/or actual barriers that are impeding a beneficiary's employment success and treatment plans should address a beneficiary's interest/desire to work or pursue a career. Documentation should refer to the beneficiary's diagnoses, employment goals, and why assistance is needed due to psychiatric symptoms interfering with achieving employment goals.

Employment Supports in CPST Treatment Plans

1. Recognizing personal signs/symptomology and establishing skills set/coping skills for a variety of settings including a work environment to address these issues;
2. Discussion about interest in terms of types of employment-environments that would work best for the person;
3. Post-employment learning to cope with balancing work/home life;
4. Identifying stressors in work environment and establishing coping mechanisms to overcome those stressors; and
5. Advocating for self in the work place (asking for a raise, time off, etc.).

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APPENDIX G-2: Employment Supports for Beneficiaries Receiving CPST and PSR

Employment Supports in PSR Treatment Plans

1. Teaching the beneficiary illness management and emotional regulation skills in the context of employment, both on and off the job;
2. Teaching the beneficiary how to focus on reframing and ordering tasks when symptoms present barriers to working;
3. Teaching the beneficiary to improve sleep hygiene and daily living activities to enhance their effectiveness in job seeking and keeping;
4. Problem solving with the beneficiary as they are contemplating employment by providing structured interviewing about the beneficiary's skills, abilities, wishes, and experiences in the area of employment;
5. Role playing with the beneficiary when they are planning interviews with potential employers to use illness management and emotional regulation skills;
6. Teaching assertiveness training and other interpersonal communication skills in the employment setting;
7. Building communications skills to learn to interact with employers/co-workers;
8. Building skills related to personal hygiene and dress and presenting oneself for job interviews/work;
9. Develop/improve time management skills to include areas specific to work schedules arriving to work when scheduled and timely;
10. Learning appropriate work habits-appropriate topics and behavior when in a work environment;
11. Skills building as it relates to where to go to look for a job, how to complete job application, etc.; and
12. Advocating for self in the work place (asking for a raise, time off, etc.)

CHAPTER 2: BEHAVIORAL HEALTH SERVICES

APPENDIX G-2: Employment Supports for Beneficiaries Receiving CPST and PSR

NOT COVERED:

The following employment supports are not allowable in the MHR Program:

1. Skills training related to a specific job (how to operate equipment, use computer programs, fill customer orders, etc.);
2. Staff presence in the workplace to assist with supervision or teaching of routine work duties;
3. Approaching potential employers to "job develop" without the beneficiary present; and
4. Presentations to the business community to seek partnerships in hiring.

Note to assertive community treatment (ACT) providers:

This guidance does not limit the tasks performed by the employment specialists within the ACT service. ACT providers should render employment support in accordance with the ACT model.