Optum

United Behavioral Health

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INTRODUCTION & INSTRUCTIONS FOR USE

The following *State or Contract Specific Clinical Criteria*[1] defined by state regulations or contractual requirements are used to make medical necessity determinations, mandated for members of behavioral health plans managed by Optum and U.S. Behavioral Health Plan, California, (doing business as Optum Health Behavioral Solutions of California ("Optum-CA")).

Other *Clinical Criteria*[2] may apply when making behavioral health medical necessity determinations for members of behavioral health plans managed by Optum®[3]. These may be externally developed by independent third parties used in conjunction with or in place of these Clinical Criteria when required, or when state or contractual requirements are absent for certain covered services. When deciding coverage, the member's specific benefits must be referenced.

All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member's benefits prior to using these Clinical Criteria. In the event that the requested service or procedure is limited or excluded from the benefit, is defined differently or there is otherwise a conflict between this Clinical Criteria and the member's specific benefit, the member's specific benefit supersedes these Clinical Criteria.

These Clinical Criteria are provided for informational purposes and do not constitute medical advice.

APPLIED BEHAVIOR ANALYSIS (ABA)

APPLIED BEHAVIOR ANALYSIS (ABA) is the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including direct observation, measurement, and functional analysis of the relations between environment and behavior. ABA therapies teach skills through the use of behavioral observation and reinforcement or prompting to teach each step of targeted behavior. ABA therapies are based on reliable evidence and are not experimental.

Admission Criteria

- The recipient is under the age of 21.
  AND
- The recipient has been diagnosed with a condition for which ABA therapy services are recognized as therapeutically appropriate, including (but not limited to) autism spectrum disorder, by a qualified health care professional.
  AND
- The recipient exhibits the presence of excesses and/or deficits of behaviors that significantly interfere with home or community activities (e.g., aggression, self-injury, elopement, etc.).
  AND
- The recipient must have the following documents submitted as a part of the prior authorization process:
  - A completed comprehensive diagnostic evaluation (CDE) indicating medical necessity, and which has been performed by a qualified health care professional (QHCP).
    - The CDE must at a minimum include:
      - A thorough clinical history with the informed parent/caregiver, inclusive of developmental and psychosocial history;

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[1] Clinical Criteria (State or Contract Specific): Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.

[2] Clinical Criteria
(Level of Care Utilization System-LOCUS) Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make medical necessity determinations and placement decisions for adults ages 19 and older.
Child and Adolescent Level of Care Utilization System/Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) Standardized assessment tool developed by the American Association of Community Psychiatrists and the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for children and adolescents ages 6-18.
(Early Childhood Service Intensity Instrument-ECSII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make medical necessity determinations and to provide level of service intensity recommendations for children ages 0-5.
(ASAM Criteria) Criteria used to make medical necessity determinations for substance-related disorder benefits.

[3] Optum is a brand used by United Behavioral Health and its affiliates.

- Direct observation of the recipient, including but not limited to, assessment of current functioning in the areas of social and communicative behaviors and play or peer interactive behaviors;
- A review of available records;
- A valid *Diagnostic and Statistical Manual of Mental Disorders,* (DSM) V (or current edition) diagnosis;
- Justification/rational for referral/non-referral for an ABA functional assessment and possible ABA services; and
- Recommendations for an additional treatment, care or services, specialty medical or behavioral referrals, specialty consultations, and/or additional recommended standardized measures, labs or other diagnostic evaluations considered clinically appropriate and/or medically necessary.
- When the results of the screening are borderline, or if there is any lack of clarity about the primary diagnosis, comorbid conditions or the medical necessity of services requested, the following categories of assessment should be included as components of the CDE and must be specific to the recipient's age and cognitive abilities:
    - Autism specific assessments;
    - Assessment of general psychopathology;
    - Cognitive assessment; and
    - Assessment of adaptive behavior.

- A QHCP is defined as any of the following:
  - Pediatric Neurologist;
  - Developmental Pediatrician;
  - Psychologist (including a Medical Psychologist), Psychiatrist (particularly Pediatric and Child Psychiatrist); or
  - Licensed individual that has been approved by the Medicaid medical director.

- A prescription for ABA therapy services ordered by a QHCP;
- A behavior treatment plan that;
  - Is person-centered and based upon individualized goals;
  - Delineates the frequency of baseline behaviors and the treatment development plan to address the behaviors;
  - Identifies long-term, intermediate, and short-term goals and objectives that are behaviorally defined;
  - Identifies the criteria that will be used to measure achievement of behavior objectives;
  - Clearly identifies the schedule of services planned and the individual providers responsible for delivering the services;
  - Includes care coordination, involving the parents or caregiver(s), school, state disability programs, and others as applicable;
  - Includes parent/caregiver training, support, and participation; Has objectives that are specific, measurable, based upon clinical observations of the outcome measurement assessment and tailored to the recipient; and
  - Ensures that interventions are consistent with ABA techniques.
  - Is submitted on the template provided by Louisiana[i] or on the provider's own form. If the provider chooses to use their own form, the provider must address all of the relevant information specified on the template including;

    The recipient's:
    - Full name;
    - Medicaid ID number;
    - Date of birth;
    - Address;
    - Home and cell phone numbers.

    The provider's:
    - Name;
    - Medicaid ID number;
    - Phone number;
    - Address;
    - Contact person's email address.
    - The recipient's diagnosis.

    The number of hours per week requested for:
    - Registered Line Technician;

- Supervision conducted by the Board-Certified Behavior Analyst – Doctoral (BCBA/-D);
- Direct services provided by a BCBA/-D, including caregiver training;
- Total number of requested hours for all services.
    - The anticipated total hours of service (therapy and supervision) each day during the school year and summer as applicable.
    - The specific criteria used to determine the need for ABA therapy at the hours requested.
    - The predominant location where services will occur.
        - If services will occur in more than one location, those additional locations should also be listed.
    - A narrative description of the baseline level of all behaviors assessed for which a goal is developed.
        - Idiosyncratic, proprietary assessment instrument results may not be used to describe baseline performance.
    - If the document is a treatment plan renewal, a description of the present level of performance for skills under treatment and any goals mastered during the previous authorization period.
    - A goal for each behavior/skill identified for treatment not including behavior reduction goals. Each goal should have a performance standard and a criterion for mastery.
        - Idiosyncratic, proprietary nomenclature may not be used to specify treatment goals.
    - If the provider is going to intervene on problem behaviors the provider must:
        - Conduct a functional assessment or a functional analysis and develop a function-based treatment plan.
        - Include the results of the functional assessment and a hypothesis statement or describe the results of a functional analysis.
        - Include the behavior topography of the problem behavior and state the frequency/duration/latency/intensity of all the problem behaviors for which a goal is developed.
        - Include behavior improvement goals with a performance standard and criteria for mastery.
        - Include the behavior intervention plan that addresses the function of the problem behavior that includes strengthening a functional replacement behavior.
        - A grid sheet with intervention tactics may be used only if it is tied to a narrative description/date analysis of the results of the functional assessment/analysis.
    - Caregiver training with a performance standard and criteria for mastery.
    - The dated signatures of the:
        - Parent/guardian:
        - Provider Representative
        - Physician
- An individualized education program (IEP) (if applicable);
    - If the IEP is not included the provider should explain why they were unable to furnish it;
    - If the services are to be delivered in a school setting, the service will not be approved until an IEP is provided.
- A waiver plan profile table and the schedule from the certified plan of care (if the recipient is in a waiver and services are being requested that will occur at the same time as waiver services).

AND

- ABA services are to be delivered in accordance with the recipient's behavior treatment plan.

AND

- ABA services will be provided by, or under the supervision of, a behavior analyst who is currently licensed by the Louisiana Behavior Analyst Board, or a licensed psychologist or licensed medical psychologist.

AND

- ABA services are to be provided in a natural setting (e.g., home and community-based settings, including clinics and school).

AND

- The member is not in imminent or current risk of harm to self, others, and/or property.

Service Delivery

- Treatment plan services should include care coordination involving the recipient's parent/caregiver.
- Services should include parent/caregiver training, support and participation.

Limitations and Exclusions

- A prior authorization period shall not exceed 180 days.
- The following services do not meet medical necessity criteria, and do not qualify as Medicaid covered ABA-based therapy services:
  - Therapy services rendered when measurable functional improvement or continued clinical benefit is not expected, and therapy is not necessary or expected for maintenance of function or to prevent deterioration;
  - Service that is primarily educational in nature;
  - Services delivered outside of the school setting that duplicate services under an individualized family service plan (IFSP) or an IEP, as required under the federal Individuals with Disabilities Education act (IDEA);
  - Treatment whose purpose is vocationally or recreationally based;
  - Custodial care that:
    - Is provided primarily to assist in activities of daily living (ADLs)
    - Is provided primarily for maintaining the recipient's or anyone else's safety; or
    - Could be provided by persons without professional skills or training; and
  - Services, supplies or procedures performed in a non-conventional setting including, but not limited to:
    - Resorts;
    - Spas;
    - Therapeutic programs; or
    - Camps

ASSERTIVE COMMUNITY TREATMENT (ACT)

ASSERTIVE COMMUNITY TREATMENT (ACT)

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.

Admission Criteria

- The member is diagnosed with one or more of the following Serious and Persistent Mental Illness (SPMI) diagnoses listed in the DSM-5 that seriously impairs their functioning in the community.
  - Schizophrenia
  - Other psychotic disorder
  - Bipolar disorder
  - Major depressive disorder
  - These may also be accompanied by any of the following:
    - Substance use disorder
    - Developmental disability

  AND
- The member meets one or more of the following:

- Two or more acute psychiatric hospitalization and/or four or more emergency room visits in the last six months.
- Persistent and severe symptoms of a psychiatric disability that interferes with the ability to function in daily life.
- Two or more interactions with law enforcement in the past year for emergency services due to mental illness or substance use (this includes involuntary commitment, ACT/Forensic Assertive Community Treatment (FACT)).
- Currently residing in an inpatient bed, but clinically assessed to be able to live in a more independent situation if intensive services were provided.
- One or more incarcerations in the past year related to mental illness and/or substance use (FACT).
- 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).
- Recommendations by probation and parole, or a judge with a FACT screening interview, indicating services are necessary to prevent probation/parole violation (FACT).

AND

- The member meets 1 of the following:
  - Inability to participate or remain engaged or respond to traditional community-based services.
  - Inability to meet basic survival needs, or residing in substandard housing, homeless or at imminent risk of becoming homeless.
  - Services are necessary for diversion from forensic hospitalization, pretrial release or as a condition of probation to a lesser restrictive setting (FACT).

AND

- The member meets 3 of the following:
  - Evidence of co-existing mental illness and substance use disorder.
  - Significant suicidal ideation, with a plan and ability to carry out within the last 2 years.
  - Suicide attempt in the last 2 years.
  - History of violence due to untreated mental illness/substance use within the last 2 years.
  - Lack of support systems.
  - History of inadequate follow-through with treatment plan, resulting in psychiatric or medical instability.
  - Threats of harm to others in the past 2 years.
  - History of significant psychotic symptomatology, such as command hallucinations to harm others.
  - Minimum LOCUS score of 3 at admission.

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

Continuing Stay Criteria

- Service provision is based on a comprehensive person-centered needs assessment must be completed within 30 days of admission. These will include:
  - Psychiatric history, status and diagnosis.
  - Level of Care Utilization System (LOCUS).
  - Telesage Outcomes Measurement System, as appropriate.
  - Psychiatric evaluation.
  - Strengths assessment.
  - Housing and living situation.
  - Vocational, educational and social interests and capacities.
  - Self-care abilities.
  - Family and social relationships.
  - Family education and support needs.
  - Physical health.
  - Alcohol and drug use.
  - Legal situation.

    - Personal and environmental resources.
        - For members participating in FACT, the assessment will include items related to court orders, identified within 30 days of admission and updated every 90 days or as new court orders are received.
- The LOCUS and psychiatric evaluation will be updated at least every six months or as needed based on the needs of each member, with an additional LOCUS score being completed prior to discharge.
- 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 of all staff involved in treatment of the member, as well as involvement of the member and collateral others of the member's choosing. The plan must contain the signature of the psychiatrist, the team leader involved in the treatment and the member (or documented refusal).
- 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.
- The treatment plan is reviewed and updated every six months. A tracking system is expected of each ACT team for services and time rendered for or on behalf of any member. The plan must consist of the following:
    - The member's specific mental illness diagnosis.
    - Plans to address all psychiatric conditions.
    - The member's treatment goals and objectives (including target dates), preferred treatment approaches and related services.
    - The member's educational, vocational, social, wellness management, and residential or recreational goals, associated concrete and measurable objectives and related services.
    - The member's goals and plans, and concrete and measurable objectives necessary for a person to get and keep their housing.
    - When psycho-pharmacological treatment is used, a specific service plan, including identification of target symptoms, medication, doses and strategies to monitor and promote commitment to medication must be used.
    - A crisis/relapse prevention plan, including and advance directive.
    - An integrated substance use and mental health service plan for individuals with co-occurring disorder (COD).
    - Any other items that are relevant for any specialized interventions, including linkages with the forensic system for consumers involved in the judicial system.
- ACT staff must be providing a minimum of 6 face to face encounters with the member monthly and must document clinically appropriate reasons if this minimum number of encounters cannot be made montly. Efforts shall be made to ensure services are provided throughout the month. At least 90 percent of services are to be delivered as community-based outreach services. The LOCUS, psychiatric evaluation and treatment plan must be updated every 6 months or as needed based on the needs of each member with an additional LOCUS score being completed prior to discharge.

Service Delivery

The ACT team must:

- 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.
- Provide mobilized CI in various environments, such as the member's home, schools, jails, homeless shelters, streets and other locations.
- Arrange or assist members to make a housing application, meet their housing obligations and gain the skills necessary to maintain their home.
- Be involved in psychiatric hospital admissions and discharges and actively collaborate with inpatient treatment staff.
- Ensure provision of culturally competent services.
- ACT team must conduct ongoing monitoring and evaluation of program implementation through the collection of process and outcome measures. Process measures should be obtained through utilization of the EBP Fidelity Scale and General Organizational Index as found within the SAMHSA ACT Toolkit. Outcome measures such as homelessness, hospitalizations (psychiatric/medical), emergency department presentations

(psychiatric/medical), incarcerations and/or arrests/detainments, substance use treatment (residential/inpatient/outpatient), utilizations of primary care physician (PCP), employment and educational status should be collected in addition to the EBP fidelity measures.

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:
  - Behavioral health services by licensed and unlicensed individuals, other than medication management and assessment.
  - Residential services, including professional resource family care.

REHABILITATION SERVICES FOR CHILDREN, ADOLESCENTS AND ADULTS

Rehabilitation Services for Children, Adolescents and Adults

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

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

COMMUNITY PSYCHIATRIC SUPPORT TREATMENT (CPST) is 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 goals or objectives as set forth in the individualized treatment plan. CPST is a face-to-face[ii] intervention with the individual present; however, family or other collaterals also may be involved. Most contacts must occur in community locations where the person lives, works, attends school and/or socializes.

CPST may include the following components:

- Development of a treatment plan: includes an agreement with the individual and family members (or other collateral contacts) on the specific strengths and needs, resources, natural supports and individual goals and objectives for that person. 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 agreement should also include developing a crisis management plan.
- Individual supportive interventions: includes problem behavior analysis as well as emotional and behavioral management with the individual member with a focus on developing skills and improving daily functional living skills. The primary focus is on implementing social, interpersonal, self-care, and independent living skill goals in order to restore stability, support functional gains, and adapt to community living. This service should not be billed as therapeutic service by licensed or non-licensed staff. Qualified LMHPs should use the appropriate CPT code when billing individual, family or group therapy.
- Skills building work: 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 of the member and to restore the fullest possible integration of the individual as an active and productive member of his or her family, community, and/or culture with the least amount of ongoing professional intervention.
- Assist the member with effectively responding to or avoiding identified precursors or triggers that would risk their remaining in a natural community location, including assisting the individual and family members or other collaterals with identifying a potential psychiatric or personal crisis, developing a crisis management plan and/or, as appropriate, seeking other supports to restore stability and functioning.

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 his or her 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.

PSR may include the following components:

- Restoration, rehabilitation and support to develop 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;
- Restoration, rehabilitation and support to develop 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; and
- Implementing learned skills so the member can remain in a natural community location and achieve developmentally appropriate functioning and assisting the individual with effectively responding to or avoiding identified precursors or triggers that result in functional impairment.

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.

Crisis Intervention may include the following components:

- 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.
- Short-term Cis, including crisis resolution and debriefing with the identified Medicaid-eligible individual.
- Follow up with the individual and, as necessary, with the individuals' caretaker and/or family members.
- Consultation with a physician or with other qualified providers to assist with the individuals' specific crisis.
- For Crisis Intervention, 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 his/her 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.
- 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.
- The CI provider must receive regularly scheduled clinical supervision from a person meeting the qualifications of an LMHP with experience regarding this specialized mental health service. The term "supervision" refers to clinical support, guidance and consultation afforded to non-licensed 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 shall comply with current, applicable scope of practice and supervisory requirements identified by their respective licensing boards.

CRISIS STABILIZATION

Crisis stabilization is intended to provide short-term and intensive supportive resources for the youth and his/her 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 his/her 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)).

Crisis Stabilization may include the following components:
- 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.
- 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.
- CS includes follow up with the individual and with the individual's caretaker and/or family members.
- CS includes consultation with a physician or with other qualified providers to assist with the individual's specific crisis.

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

Considerations for 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:
- Restoration of positive family/caregiver relationships;
- Prosocial peer relationships;
- Community connectedness/social belonging; and
- The ability to function in a developmentally appropriate home, school, vocational and community settings.

Services should provide skills building and supports that build on existing strengths and target goals related to these key developmental needs and protective factors. Children/adolescents who are in need of specialized behavioral health services shall be served within the context of the family and not as an isolated unit.

Considerations for 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 and to prevent 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, or a co-occurring diagnosis of mental health and substance use.

Rehabilitation services are expected to achieve the following outcomes:

- Assist individuals in the stabilization of acute symptoms of illness;
- Assist individuals in coping with the chronic symptoms of their illness;
- Minimize the aspects of their illness which makes it difficult for persons to live
- independently;
- Reduce or prevent psychiatric hospitalizations;
- Identify and develop strengths; and
- 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 his or her choice while striving to achieve his or her full potential.

Ten components of recovery are as follows:

- Self-Direction;
- Individualized and Person Centered;
- Empowerment;
- Holistic;
- Non-Linear;
- Strengths-Based;
- Peer Support;
- Respect;
- Responsibility; and
- Hope.

Admission Criteria for Adults and Children/Adolescents

- 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 his/her best age-appropriate functional level.
- Individuals, 21 years of age and older, who meet Medicaid eligibility, shall qualify to receive adult mental health rehabilitation services if medically necessary in accordance with LAC 50:I.1101, if the member presents with mental health symptoms that are consistent with a diagnosable mental disorder, and the services are therapeutically appropriate and most beneficial to the member.
- An adult with a diagnosis of a substance use disorder or intellectual/developmental disability without an additional co-occurring qualifying mental health diagnosis shall not meet the criteria for adult mental health rehabilitation services.

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

- 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:

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

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.

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

Service Delivery

All mental health services must be medically necessary in accordance with LAC 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:

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

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

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

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

Assessment

- Each member shall be assessed and shall have a treatment plan developed based on that assessment.
- Assessments shall be performed by an LMHP, and for children and adolescents shall be completed with the involvement of the primary caregiver.
- Assessments must be performed at least every 365 days or as needed, any time there is a significant change to the member's circumstances.

Treatment Plan Development

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

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

The treatment plan must include:

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

Treatment Plan Oversight

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

The member shall receive a signed copy of the plan upon completion and after each revision. A copy of the treatment plan should also be sent to all of the individuals involved in implementing and monitoring the treatment plan. The treatment plan should not include services that are duplicative, unnecessary or inappropriate.

Limitations/Exclusions

- Components that are not provided to, or directed exclusively toward, the treatment of the Medicaid eligible individual.
- Services provided at a work site, which are job-oriented and not directly related to the treatment of the member's needs.
- These rehabilitation services shall not duplicate any other Medicaid State Plan service or service otherwise available to the member at no cost.
- 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.

FUNCTIONAL FAMILY THERAPY AND FUNCTIONAL FAMILY THERAPY – CHILD WELFARE

FUNCTIONAL FAMILY THERAPY (FFT) is a systems-based model of prevention and intervention that incorporates various levels of the member's interpersonal experiences to include cognitive, emotional and behavioral experiences, as well as interpersonal perspectives which focus on the family and other systems within the environment that impact the member and their family system.

FFT is a strengths-based model that emphasizes the use of existing resources of the member, their family and those of the involved multi-system. The goal is to foster resilience and decrease incidents of disruptive behavior. The service aims to reduce intense/negative behavioral patterns, improve family communication, parenting practices and problem-solving skills, and increase the family's ability to access community resources.

FFT services target members between the ages of 10-18 primarily demonstrating significant externalizing behaviors or at risk for developing more severe behaviors, which affect family functioning. Behaviors include antisocial behavior or acts, violent behaviors and other behavioral issues that impair functioning. The member may also meet criteria for a disruptive behavior disorder (ADHD, ODD and/or conduct disorder). Members with other mental health conditions, such as Anxiety

and Depression, may also be accepted as long as the existing condition manifests in outward behaviors that impact the family and multiple systems. Youth with substance use issues may be included if FFT is deemed clinically more appropriate than focused drug and alcohol treatment and acting out behaviors are present to the degree that function is impaired, and the criteria listed below is met.

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, oppositional defiant disorder 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 FFTCW 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 is met:

Admission Criteria

- The member is not in imminent or current risk of harm to self, others, and/or property.
  AND
- The member is 10-18 years old for FFT; Families of youth, ages 0-18 for FFT-CW.
  AND
- At least one adult caregiver is available to provide support and is willing to be involved in treatment.
  AND
- The member's DSM-5 diagnosis is the primary focus of treatment and symptoms, and impairment are the result of a primary disruptive/externalizing behavior disorder, although internalizing psychiatric conditions and substance use disorders may be secondary.
  AND
- Functional impairment is not solely a result of pervasive developmental disorder or intellectual disability.
  AND
- The member displays externalizing behavior which adversely affects family functioning. The member's behaviors may also affect functioning in other areas.
  AND
- Documented medical necessity for an intensive in-home service.

Continuing Stay Criteria

- The member receives an average of 12 to 30 one-to-two-hour sessions in the home or community depending on the member's needs over the course of 3-5 months.

Discharge Criteria

- The member and family demonstrate their ability to utilize resources within the community and demonstrate integration prior to discharge.

HOMEBUILDERS

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) 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 the Institute for Family Development (IFD). Homebuilders® participants demonstrate the following characteristics:

- Children/youth with serious behavioral and/or emotional problems in the home, school, and/or community;
- Family members with substance abuse problems, mental health problems, poverty-related concerns (lack of adequate housing, clothing and/or food);

- Babies that were born substance-exposed or considered failure to thrive;
- 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);
- Children/youth who have experienced abuse, neglect, or exposures to violence or other trauma.

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. 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:

- Caregiver and/or child emotional/behavioral management problems;
- Trauma exposure;
- Incorrigibility;
- Academic problems;
- Delinquency;
- Truancy;
- Running away;
- Family conflict and violence;
- Poor/ineffective parenting skills;
- Single parent families;
- Sibling antisocial behavior;
- Parental/caregiver use of physical punishment, harsh, and/or erratic discipline practices;
- Substance use;
- Mental health concerns (depression/mood disorders, anxiety, etc.); and/or
- Additional topics such as: poverty, lack of education, substandard housing, lack of supports and resources.

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 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® consists of:

- 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;
- 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
- Crisis Intervention: Homebuilders therapists are available 24/7 for telephone and face to face crisis intervention.

Admission Criteria

- The member is not in imminent or current risk of harm to self, others, and/or property.
  AND
- The family has a child/children ages birth to 18 years old at imminent risk of out of home placement due to at least one of the following:
  - Caregiver and/or child emotional/behavioral management problems
  - Trauma exposure

- Incorrigibility
- Academic problems
- Delinquency
- Truancy
- Running away
- Family conflict and violence
- Poor/ineffective parenting skills
- Single parent families
- Sibling antisocial behavior
- Parental/caregiver use of physical punishment, harsh, and/or erratic discipline practices
- Substance use
- Mental health concerns (depression/mood disorders, anxiety, etc.)
- Additional topics such as: poverty, lack of education, substandard housing, lack of supports and resources

AND

- Other than psychological evaluation or assessment and medication management, all behavioral health services are provided by Homebuilders.
  AND
- The member is not receiving residential services including professional resource family care.

Continuing Stay Criteria

- The member is receiving an average of 8 to 10 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.
  AND
- Homebuilders' therapists are available 24/7 for telephone and face to face crisis intervention.

Discharge Criteria

- The duration of services is 4 to 6 weeks. Extensions beyond 4 weeks must be approved by the Homebuilders consultant. Two aftercare 'booster sessions' totaling 5 hours are available in the 6 months following referral. Additional booster sessions may be approved.

Exclusions

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.

INDIVIDUAL PLACEMENT AND SUPPORT

Individual Placement and Support Services 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.

Admission Criteria

- The member meets the LA definition of Medical Necessity[iii]
- The member is at least 21 years of age and
- The member has transitioned from a nursing facility or been diverted from nursing facility level of care.

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, substance abuse, mental health symptoms, history of violent behavior, cognition impairment, treatment non-adherence, homelessness, work history, psychiatric hospitalizations, homelessness, level of disability, legal system involvement, or personal presentation.

Service Delivery

- 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. 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. IPS specialists participate in weekly IPS unit meetings, mental health treatment team meetings for each team to which they are assigned, and LRS meetings.
    - The employment unit has weekly client-based 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.
    - 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.
    - 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.
    - 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.
- 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. Initial vocational assessment occurs over 2-3 sessions, 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. A vocational 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 (referred to as the "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 employment assessment occurs within 30 days after program entry.

- An individualized job search plan is developed and updated with information from the vocational assessment/profile form and new job/educational experiences.
- 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.
- 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 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.
- 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.
- 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. 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 at least monthly for a year or more, on average, after working steadily, and desired by members. 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 provide employer support (e.g., educational information, job accommodations) at a member's request.
- Service termination is not based on missed appointments or fixed time limits. 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. Once it is clear that the member no longer wants to work or continue with IPS services, the IPS specialist stops outreach.
- There shall be member involvement throughout the planning and delivery of services. Services shall be:
    - Delivered in a culturally and linguistically competent manner;
    - Respectful of the member receiving services;
    - Appropriate to members of diverse racial, ethnic, religious, sexual and gender identities and other cultural and linguistic groups; and
    - Appropriate for age, development, and education.
    - Any licensed practitioner providing behavioral health services must operate within their license and scope of practice.

Crisis Response Services for Adults

Crisis Response Services for adults 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 twenty-four (24) hours a day, seven (7) 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 should not replace existing behavioral health services. Rather crisis response services should be used for new or unforeseen crises not otherwise addressed in the member's existing crisis plan. These services are not to be utilized as step down services from residential or inpatient psychiatric or Substance Use Disorder (SUD) treatment service settings and 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.

MOBILE CRISIS

Mobile Crisis Intervention (MCI) services are an initial or emergent crisis intervention response intended to provide relief, resolution and intervention through crisis supports and services during the first phase of a crisis in the community. MCI is a face-to-face, time-limited service provided to a member who is experiencing a psychiatric crisis 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. 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. All activities must occur within the context of a potential or actual psychiatric crisis. MCI services are not intended for and should not replace existing behavioral health services, rather it should be used for new or unforeseen crises not otherwise addressed in the member's existing crisis plan, including unanticipated after hours, weekend and holiday crisis events. MCI services are not to be utilized as step down services from residential or inpatient psychiatric service settings and are not intended to substitute for already-approved and accessible Community Psychiatric Support and Treatment (CPST), Psychosocial Rehabilitation (PSR), Assertive Community Treatment (ACT) services with a member's already-established provider. This service is intended for a member with urgent mental health distress only.

Mobile Crisis providers are dispatched after an initial triage screening determines that MCI is the most appropriate service. MCI services are available twenty-four (24) hours a day, seven (7) days a week and must include maximum one (1) hour urban and two (2) hour rural face-to-face/onsite response times.

Admission 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 twenty-one (21) years and over to his/her best age-appropriate functional level.
    - Members 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.
- All members 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 for initial/emergent crisis intervention services as long as medical necessity is met and the members is not already linked to an existing MHR or ACT provider.

Continued Service Criteria

- MCI is an initial crisis intervention and is allowed without the requirement of a prior authorization in order to address the emergent issues in a timely manner. MCI is intended to provide crisis supports and services during the first 72 hours of a crisis.
    - Note: Such initial encounters will be subject to retrospective review. In this way, IF it is determined that the response time is beyond one (1) – two (2) 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.

- This service must be provided under the supervision of an LMHP with experience regarding this specialized mental health service. The LMHP or physician 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.

Discharge Criteria

- Crisis care should 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.

Service Delivery

- 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 or some other exception as documented in the member record. When preferred, office-based services are permitted but should not be the primary mode of service delivery.
- A brief preliminary, person-centered determination of risk, mental status, medical stability and the need for further evaluation or other mental health services must be conducted and 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 further evaluation is needed, the psychiatric diagnostic evaluation must be conducted by an LMHP or physician with experience regarding this specialized mental health service. This evaluation should include contact with the member, family members or other collateral sources 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 collaterals sources, it must be documented in the member record.
- 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 after the current crisis to mitigate risk of future incidents until the member engages in alternative services, if appropriate.
- 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.
- Service planning and care coordination include the following:
    - Coordinating the transfer to alternate levels of care when warranted, including but not limited to:
        - Primary medical care - when the member requires primary medical care with an existing provider.
        - Community based behavioral health provider - when the 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.
        - Behavioral Health Urgent Care Center (BHUCC) - when the member requires ongoing support and time outside of the home.
        - Community Brief Crisis Support (CBCS) - when the member requires ongoing support at home or in the community.
        - Crisis Stabilization (CS) – when the 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.
        - Inpatient treatment – when the member is in medical crisis, experiencing severe intoxication or withdrawal episodes, actively suicidal, homicidal, gravely disabled, or currently violent.
        - Residential substance use treatment - when the member requires ongoing support outside of the home for a substance use disorder.
    - Coordinating to link the member with no current behavioral health provider and/or primary medical care provider to outpatient services as indicated.

- o Providing any member records to the existing or new behavioral health provider or another crisis service to assist with continuing care.
- o Providing follow up to the member and authorized member's caretaker and/or family up to seventy-two (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:
  - Telephonic or face to face follow-up based on a clinical individualized need;
  - 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; and
  - Alternate modes of communication (e.g., texts) are allowed if preferred by the member and documented in the member's record.

Exclusions

- The initial MCI contact cannot be rendered in emergency departments (EDs). The MCI provider is allowed to continue a 72-hour encounter if it was initiated prior to the ED visit.
- MCI services cannot be rendered in substance use residential facilities or inpatient facilities.
- MCI services cannot be approved for incarcerated individuals.
- MCI services are not to be utilized as step down services from residential or inpatient psychiatric service settings.

BEHAVIORAL HEALTH CRISIS CARE

Behavioral Health Crisis Care (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 (BHCCC) operate twenty-four (24) hours a day, seven (7) 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). BHCCC are designed to offer recovery oriented and time limited services up to twenty-three (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.

Admission 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 twenty-one (21) years and over to his/her 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.

Continued Stay Criteria

- 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 MCO when its member presents. If the referral is made from CBCS to BHCC, prior authorization is required.

Discharge Criteria

- BHCC is intended to provide crisis supports and services during the first twenty-three (23) hours of a crisis.

Service Delivery

- Provide services (screening, assessment, interventions, and care coordination) as outlined in the general section;
- A registered nurse or licensed practical nurse practicing within the scope of his or her license performs a medical screen to evaluate for medical stability; and

- Providing follow up to the member and authorized member' s caretaker and/or family within twenty-four (24) hours as appropriate and desired by the member and up to seventy-two (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:
    - Telephonic follow-up based on clinical individualized need; and
    - 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.

Exclusions

- BHCC is not to be utilized as step down services from other residential or inpatient psychiatric service settings or Substance Use Disorder residential service settings.

COMMUNITY BRIEF CRISIS SUPPORT

Community Brief Crisis Support (CBCS) services are an ongoing crisis response intended to be rendered for up to fifteen (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 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.

CBCS services are available twenty-four (24) hours a day, seven (7) days a week. CBCS services are not intended for and should not replace existing behavioral health services. Rather referrals for services occur directly from Mobile Crisis Response (MCR), Behavioral Health Crisis Care (BHCC), or crisis stabilization (CS) providers as needed for ongoing follow up and care. This level of care involves supporting and collaborating with the member to achieve symptom reduction by problem solving and developing useful safety plans that will assist with community tenure.

Admission 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 twenty-one (21) years and over to his/her best age-appropriate functional level. This service will be rendered to eligible members after a referral is made from MCR, BHCC, or CS. 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.

Continued Stay Criteria

- 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. Additional units may be approved with prior authorization.

Discharge Criteria

- The member's treatment record must reflect relief, resolution and problem solving of the identified crisis or referral to an alternate provider.

Service Delivery

- Provide services (screening, assessment, interventions, and care coordination) as outlined in the general section; and
- Providing follow up to the member and authorized member's caretaker and/or family within twenty-four (24) hours as appropriate and desired by the member and up to fifteen (15) days following initial contact with the CBCS provider once the previous CI (MCR, BHCC, CS)

provider has discharged the member to ensure continued stability post crisis for those not accessing higher levels of care, including but not limited to:

- Telephonic or face to face follow-up based on clinical individualized need; and
- 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.

Exclusions

- CBCS services cannot be rendered in emergency departments (EDs);
- CBCS services cannot be rendered in substance use residential facilities or inpatient
- facilities;
- CBCS services cannot be approved for incarcerated individuals;
- CBCS services are not to be utilized as step down services from other residential or inpatient psychiatric service settings; and
- 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 should not prohibit a brief overlap of services that is necessary for a warm handoff to the accepting provider, when appropriate.

MULTISYSTEMIC THERAPY (MST)

MULTISYSTEMIC THERAPY (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.

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 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.

Admission Criteria

- The member is 12-17 years old.
  AND
- The member exhibits significant externalizing behavior, such as chronic or violent juvenile offenses.
  AND
- The member is at risk for out-of-home placement or is transitioning back from an out-of-home setting.
  AND
- The member has externalizing behaviors and symptomatology resulting in a DSM-5 diagnosis of Conduct Disorder or other diagnoses consistent with such symptomatology.
  AND
- There is ongoing multiple system involvement due to high-risk behaviors and/or risk of failure in mainstream school settings due to behavioral problems.
  AND
- Less intensive treatment has been ineffective or is inappropriate.
  OR
- The member's treatment planning team or CFT recommends that he/she participate in MST.

Continuing Stay Criteria

- Treatment does not require more intensive level of care.
  AND

- The treatment plan has been developed, implemented and updated based on the member's clinical condition and response to treatment, as well as the strengths of the family, with realistic goals and objectives clearly stated.
  AND
- 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
- The family is actively involved in treatment, or there are active, persistent efforts being made which are expected to lead to engagement in treatment.

Discharge Criteria

- The member's treatment plan goals or objectives have been substantially met.
  AND
- The member meets criteria for a higher or lower level of treatment, care or services.
  AND
- The member, 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
- Consent for treatment has been withdrawn, or the member 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.

Service Delivery

- MST services may not be clinically appropriate for individuals who meet the following conditions:
  - Members who meet the criteria for out-of-home placement due to suicidal, homicidal or psychotic behavior.
  - Members living independently or members whom a primary caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends or other potential surrogate caregivers.
  - The referral problem is limited to serious sexual misbehavior in the absence of other delinquent or antisocial behavior.
  - Youth with moderate to severe difficulties with social communication, social interaction, and repetitive behaviors, which may be captured by a diagnosis of autism;
  - Low-level need cases or;
  - Members who have previously received MST services or other intensive family- and community-based treatment.

Exclusions

- MST services are comprehensive of all other services, with the exception of psychological evaluation or assessment and medication management.
- MST shall not be billed in conjunction with residential services, including professional resource family care.

OUTPATIENT SERVICES

OUTPATIENT SERVICES are assessment and diagnosis and active behavioral health treatment that are provided in an ambulatory setting. The course of treatment in Outpatient is focused on addressing the factors that precipitated admission (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the factors that precipitated admission no longer require treatment.

Admission Criteria

- Members are adults or children that meet medical necessity criteria.

Service Delivery

- Allowed modes of service are individual, family, group, on-site, off-site, and tele-video.
- When covered, licensed Practitioner Outpatient Therapy includes:
  - Outpatient psychotherapy (individual, family and group);

- Psychotherapy for crisis;
- Psychoanalysis;
- Electroconvulsive therapy;
- Biofeedback;
- Hypnotherapy;
- Screening, assessment, examination, and testing;
- Diagnostic evaluation;
- Medication management; and
- Case conference* (CSoC only).

A licensed mental health professional (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 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).

- 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.
- Assessments, evaluations, individual psychotherapy, family psychotherapy, and medication management services may be reimbursed when provided via telecommunication technology. The LMHP is responsible for acting within the telehealth scope of practice as decided by their licensing board.
- "Healthcare provider," as used herein, means a person, partnership, limited liability partnership, limited liability company, corporation, facility, or institution licensed or certified by this state to provide health care or professional services as a physician assistant, hospital, nursing home, registered nurse, advanced practice registered nurse, licensed practical nurse, psychologist, medical psychologist, social worker, or licensed professional counselor. See La. R.S. 40:1223.3(3).
- "Telehealth," as used herein, means a mode of delivering healthcare services that utilizes information and communication technologies to enable the diagnosis, consultation, treatment, education, care management, and self-management of patients at a distance from healthcare providers. See La. R.S. 40:1223.3(6). Additionally, "telehealth" means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between a provider and a patient. Telehealth allows services to be accessed when providers are in a distant site and patients are in the originating site. Telehealth facilitates patient self-management and caregiver support for patients.

PEER SUPPORT SERVICES

Peer support services (PSS) are an evidence-based behavioral health service that consists of a qualified peer support provider, who assists members with their recovery from mental illness and/or substance use. The PSS are provided by Certified Peer Support Specialists (CPSS), who are individuals with personal lived experience with recovery from behavioral health conditions and successfully navigating the behavioral health services system. PSS are 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. PSS are person-centered and recovery focused. PSS are face-to-face interventions with the member present. Most contacts occur in community locations where the member lives, works, attends school and/or socializes.

Peer Support Services, or Consumer Operated Services, are recognized by SAMHSA as an Evidence-Based Practice. PSS is 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 disorder need opportunities to identify and choose for themselves their desired roles with regard to living, learning, working and social interaction in the community.

Admission Criteria

- The member is 21 years of age or older; and
- The member has a mental illness and/or substance use disorder diagnosis

Service Delivery

- PSS include a range of tasks to assist the member during the recovery process. Recovery planning assists members to set and accomplish goals related to home, work, community and health. PSS may include, but are not limited to:
    - Utilizing 'lived experience' to translate and explain the recovery process step by step and expectations of services;
    - Assisting in the clinical process through:
        - providing feedback to the treatment team regarding identified needs of the member and the level of engagement of the member;
        - development of goals;
        - acting as an advocate, with the permission of the member, in the therapeutic alliance between the provider and the member;
        - encouraging a member with a low level of engagement to become actively involved in treatment; and
        - ensuring that the member is receiving the appropriate services of their choice and in a manner consistent with confidentiality regulations and
        - professional standards of care;
    - Rebuilding, practicing, and reinforcing skills necessary to assist in the restoration of the member's health and functioning throughout the treatment process;
    - Providing support to the member to assist them with participation and engagement in meetings and appointments
    - Assist members in effectively contributing to planning and accessing services to aid in the member's recovery process
    - Aiding the member in identifying and overcoming barriers to treatment and support member in communicating these barriers to treatment and service providers;
    - Assisting the member with supporting strategies for symptom/behavior management;
    - Supporting the member to better understand their diagnoses and related symptoms;
    - Assisting the member with finding and using effective psychoeducational materials;
    - Assisting the member to identify and practice self-care behaviors, including but not limited to developing a wellness recovery plan and relapse prevention planning;
    - Explaining service and treatment options;
    - Assisting the member to develop support systems with family and community members;
    - • 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;
    - • 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;
    - Functioning as part of the member's clinical team to support the principles of self-direction to:
        - Assist and support the member to set goals and plan for the future;
        - Propose strategies to help the member accomplish tasks or goals; and
        - Support the member to use decision-making strategies when choosing services and supports; and
    - Providing support necessary to ensure the member's engagement and active participation in the treatment planning process.
    - Support the member to arrange services that will assist them to meet their treatment plan goals, inclusive of identifying providers such as:
        - primary care services;
        - behavioral health management and treatment services;
        - local housing support programs;

        - supportive employment;
        - education, other supportive services;
        - referral to other benefit programs; and
        - arranging non-emergency medical transportation.
    - Provides support with transitioning members from a nursing facility and adjustment to community living.
    - There shall be member involvement throughout the planning and delivery of services. Services shall be:
        - Delivered in a culturally and linguistically competent manner;
        - Respectful of the member receiving services;
        - Appropriate to members of diverse racial, ethnic, religious, sexual and gender identities and other cultural and linguistic groups; and
        - Appropriate for age, development, and education.

Limitations/Exclusions

- The following services shall be excluded from Medicaid coverage and reimbursement:
    - Services that are purely recreational, social or leisure in nature, or have no therapeutic or programmatic content;
    - Peer support services that are provided to members as an integral part of another covered Medicaid service;
    - Transportation;
    - General office/clerical tasks; and
    - Attendance in meetings or sessions without a documented purpose/benefit from the peer's presence in that meeting or session.

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.

Admission 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
- Members must be medically stable, not enrolled in a Medicaid-funded program which offers a personal care service or related benefit, and whose care needs do not exceed that which can be provided under the scope and/or service limitations of this personal care service.

Discharge Criteria

- 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:
    - 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;
    - Written notice shall be made via certified mail, return receipt requested and shall be in a language and manner that the member understands;
    - A copy of the written discharge/transfer notice shall be put in the member's record;
    - 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;
    - The written notice shall include the following:
        - A reason for the transfer or discharge;
        - The effective date of the transfer or discharge;
        - An explanation of a member' s right to personal and/or third parties' representation at all stages of the transfer or discharge process;
        - Contact information for the Advocacy Center;
        - Names of provider personnel available to assist the member and family in decision making and transfer arrangements;

        - The date, time and place for the discharge planning conference;
        - A statement regarding the member's appeal rights;
        - The name of the director, current address and telephone number of the Division of Administrative Law; and
        - A statement regarding the member's right to remain with the provider and not be transferred or discharged if an appeal is timely filed.
- Provider transfer or discharge responsibilities shall include:
    - Holding a transfer or discharge planning conference with the member, family, case manager (if applicable), legal representative and advocate, if such is known;
    - 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 his/her needs;
    - 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
    - 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 Delivery

- Personal care services include the following:
    - 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.
    - 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:
        - Light housekeeping, including ensuring pathways are free from obstructions;
        - Laundry of the member's bedding and clothing, including ironing;
        - Food preparation and storage;
        - Assistance with scheduling (making contacts and coordinating) medical appointments;
        - Assistance with arranging transportation depending on the needs and preferences of the member;
        - Accompanying the member to medical and behavioral health appointments and providing assistance throughout the appointment;
        - Accompanying the member to community activities and providing assistance throughout the activity;
        - Brief occasional trips outside the home by the direct service worker 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
        - Medication reminders with self-administered prescription and non-prescription medication that is limited to:
    - Verbal reminders;
    - Assistance with opening the bottle or bubble pack when requested by the member;
    - Reading the directions from the label;
    - Checking the dosage according to the label directions; or
    - 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.
- 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.
- There shall be member involvement throughout the planning and delivery of services. Services shall be:
    - Delivered in a culturally and linguistically competent manner in accordance with member's preferences and needs;

    - Respectful of the member receiving services;
    - Appropriate to members of diverse racial, ethnic, religious, sexual and gender identities and other cultural and linguistic groups; and
    - Appropriate for age, development, and education.
- 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.

Limitations/Exclusions

- PCS is limited to a maximum of 20 hours per week. Exceptions may be approved by the Medicaid managed care medical director based on medical necessity.
- 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.
- Services must be provided in home and community-based settings, and may not be provided in the following settings:
    - In a home or property owned, operated, or controlled by an owner, operator, agent, or employee of a licensed provider of personal care services.
    - In the direct service worker's home.
    - In a nursing facility, Intermediate Care Facility for the Developmentally Disabled, Institute for Mental Disease, or other licensed congregate setting.
- There shall be no duplication of services.
    - 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.
    - 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.
    - 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.
- PCS shall not supplant care provided by natural supports.
- PCS does not include room and board, maintenance, upkeep, and/or improvement of the member's or family's residence.
- PCS may not be provided outside the state of Louisiana unless a temporary exception has been approved by the Medicaid managed care entity.
- Direct service workers may not work more than 16 hours in a 24-hour period.
- The following individuals are prohibited from being reimbursed for providing services to a member:
    - Biological, legal or step first, second, third or fourth degree relatives.
    - First-degree relatives include parents, spouses, siblings, and children.
    - Second-degree relatives include grandparents, grandchildren, aunts, uncles, nephews, and nieces.
    - Third-degree relatives include great-grandparents, great-grandchildren, great aunts, great uncles, and first cousins.
    - Fourth-degree relatives include great-great grandparents, great-great grandchildren, and children of first cousins.
    - Curator, tutor, legal guardian, authorized representative, and any individual who has power of attorney.

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF)

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF)

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.

Admission Criteria

- Children under 21 years of age, pre-certified by an independent team, where: Ambulatory care resources available in the community do not meet the member's treatment needs.
- Proper treatment of the member's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
- The services can be reasonably expected to improve the member's condition or prevent further regression, so that the services will no longer be needed.
- The independent team pre-certifying the PRTF stay must:
    - Include a physician;
    - Have competence in diagnosis and treatment of mental illness, preferably in child psychiatry; and
    - Have knowledge of the individual's situation.

Service Delivery

- 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 recipient's discharge from inpatient status at the earliest possible time. "Individual POC" means a written plan developed for each member to improve his condition to the extent that inpatient care is no longer necessary.
- The POC will:
    - Be based on a diagnostic evaluation conducted within the first 24 hours of admission in consultation with the youth and the parents/legal guardian that includes examination of the medical, psychological, social, behavioral and developmental aspects of the recipient's situation and reflects the need for inpatient psychiatric care;
    - Be developed by a team of professionals in consultation with the child and the parents, legal guardians or others in whose care the youth will be released after discharge;
    - State treatment objectives;
    - Prescribe an integrated program of therapies, activities and experiences designed to
    - meet the objectives; and
    - Include, at an appropriate time, post-discharge plans and coordination of inpatient services, with partial discharge plans and related community services to ensure continuity of care with the member's family, school and community upon discharge.
- The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to:
    - Determine that services being provided are or were required on an inpatient basis; and
    - Recommend changes in the plan, as indicated by the member's overall adjustment as an inpatient.
- 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.
    - The facility treatment team develops and reviews the individual POC. The individual POC must be developed by an interdisciplinary team of physicians and other personnel who are employed by, or provide services to, patients in the facility. Based on education and experience, preferably including competence in child psychiatry, the team must be capable of:
        - Assessing the beneficiary's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities;
        - Assessing the potential resources of the beneficiary's family;
        - Setting treatment objectives; and
        - Prescribing therapeutic modalities to achieve the plan's objectives.

Limitations and Exclusions

- The PRTF is compliant with seclusion and restraint requirements.
- 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.
- The PRTF reasonable activities are child-specific and necessary for the health and maintenance of health of the child while he or she is a resident of the facility.
- Medically necessary care constitutes 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 inhouse 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 inhouse while the child is in a PRTF.

THERAPEUTIC GROUP HOME

THERAPEUTIC GROUP HOME (TGH) Children and Adolescents

A Therapeutic Group Home provides a community-based residential service in a home-like setting of no greater than 10 beds under the supervision and program oversight of a psychiatrist or psychologist. TGHs are located in residential communities in order to facilitate community integration through public education, recreation and maintenance of family connections. TGHs deliver an array of clinical and related services within the home, including psychiatric supports, integration with community resources and skill-building taught within the context of the home-like setting. The treatment should be targeted to support the restoration of adaptive and functional behaviors that will enable the child or adolescent to return to and remain successfully in his/her home and community, and to regularly attend and participate in work, school or training, at the child's best possible functional level.

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.

Admission 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 his/her 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.

- The supervising practitioner should review the referral Pretreatment Assessment at admission or within 72 hours of admission and prior to service delivery.
- The member requires a twenty-four (24) hours/day, seven (7) days/week, structured and supportive living environment.
    - 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.
    - The psychiatrist or psychologist/medical psychologist must provide twenty-four (24) hour, on-call coverage seven (7) days a week.

Service Delivery: Assessment and Treatment Planning

- The supervising practitioner must complete an initial diagnostic assessment at admission or within seventy –two (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
- 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.
- 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.

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

Service Delivery: 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.

Service Exclusions

- Components that are not provided to or directed exclusively toward the treatment of the Medicaid eligible member;
- Services provided at a work site which are job tasks oriented and not directly related to the treatment of the member's needs;
- Any services or components in which the basic nature of which are to supplant housekeeping, homemaking, or basic services for the convenience of a member receiving substance use treatment services;
- Services rendered in an institution for mental disease (IMD);
- Room and board; and
- Supervision associated with the child's stay in the TGH.

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Louisiana Medicaid Program, Chapter 2, Behavioral Health Services, Section 2.3 Outpatient Services – Individual Placement and Support.

Louisiana Medicaid Program, Chapter 2, Behavioral Health Services, Mobile Crisis Intervention.

Louisiana Medicaid Program, Chapter 2, Behavioral Health Services, Section 2.3 Outpatient Services – Personal Care Services.

REVISION HISTORY

Date	Action/Description
05/09/2018	• Combined previously separate LOCGs into one document • Multi-Systemic Therapy (MST). Some previous admission criteria were moved to best practices and the exception section was added.
08/19/2019	• Updates to the following per state language for 2019: ○ Admission Common Criteria ○ Assertive Community Treatment Admission Criteria ○ Therapeutic Group Homes number of beds
05/18/2020	• State approval
08/24/2020	• Revision of CPST and PSR assessment timelines
03/15/2021	• State manual and Peer Support additions
02/22/2022	• Annual Review and addition of IPS, Crisis Response and PCS.

[i] Behavior treatment plan template can be found at www.lamedicaid.com. It is included in the Applied Behavior Analysis Provider Manual.

[iii] 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.

In order to be considered medically necessary, services must be:

- 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
- those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the recipient.
- 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 recipient 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.