PROVIDER*ALERT*

AmeriHealth Caritas Louisiana

To: **AmeriHealth Caritas Louisiana Providers**

Date: **October 1, 2024**

Subject: **LDH Approved Clinical Policy**

Summary: Guideline for Psychosocial Rehabilitation Services for Children, Adolescents, and Adults.

AmeriHealth Caritas Louisiana would like to inform you of a new policy that has been approved by the Louisiana Department of Health in accordance with La. R.S. 46:460.54. The guideline is effective on **October 31, 2024** and will be posted at the following link on our website under Clinical Policies: https://www.amerihealthcaritasla.com/provider/resources/clinical/policies.aspx.

1. Psychosocial Rehabilitation Services for Children, Adolescents, and Adults

Reminder: If your practice is not registered with our website portal-NaviNet, we highly recommend registering. To register, please visit www.navinet.net to sign up or contact your Provider Account Executive for details.

Questions: Thank you for your continued support and commitment to the care of our members. If you have questions about this communication, please get in touch with AmeriHealth Caritas Louisiana Provider Services at 1-888-922-0007 or your Provider Network Management Account Executive.

Missed an alert? You can find a complete list of provider alerts on our website's Provider Newsletters and Updates page.

Need to update your provider information? Send full details to network@amerihealthcaritasla.com.

Psychosocial rehabilitation services for children, adolescents, and adults

Plan: AmeriHealth Caritas Louisiana

Clinical Policy ID: CCP.4038

Recent review date: 5/2024

Next review date: 8/2025

Policy contains: Psychosocial rehabilitation services.

AmeriHealth Caritas Louisiana has developed clinical policies to assist with making coverage determinations. AmeriHealth Caritas Louisiana's clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of medically necessary, and the specific facts of the particular situation are considered by AmeriHealth Caritas Louisiana, on a case by case basis, when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. AmeriHealth Caritas Louisiana's clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. AmeriHealth Caritas Louisiana's clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, AmeriHealth Caritas Louisiana will update its clinical policies as necessary. AmeriHealth Caritas Louisiana's clinical policies are not guarantees of payment.

Policy statement

Psychosocial rehabilitation services are clinically proven and, therefore, may be medically necessary when provided as part of a comprehensive specialized psychiatric program available to members with significant functional impairments resulting from an identified mental health disorder diagnosis to promote the maximum reduction of symptoms and restoration to their best age-appropriate functional level, and when the following criteria are met.

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

Criteria 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.

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

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

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

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

Criteria for adults

The expected outcome for adult members is to reduce the disability resulting from mental illness and assist in the recovery and resiliency of the member. 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 member's capacity for independent living, to prevent emergency department utilization and or limit the periods of inpatient treatment. The principles of recovery are the foundation for rehabilitation services. These services are intended for a member with a mental health diagnosis only, a co-occurring diagnosis of mental health and substance use disorder, or a co-occurring diagnosis of mental health and intellectual/developmental disability.

Rehabilitation services are expected to achieve the following outcomes:

- Assist members in the stabilization of acute symptoms of illness;
- Assist members in coping with the chronic symptoms of their illness;
- Minimize the aspects of their illness which makes it difficult for members to live independently;
- Reduce or prevent psychiatric hospitalizations;
- Identify and develop strengths; and
- Focus on recovery.

Additional adult eligibility criteria for psychosocial rehabilitation

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

Adult members receiving psychosocial rehabilitation services:

- Must have at least a level of care of three on the Level of Care Utilization System.
- Must meet the Substance Abuse and Mental Health Services Administration definition of serious mental illness as evidenced by a rating of three or greater on the functional status domain on the Level of Care Utilization System rating.
- Must have a diagnosable mental disorder that substantially interferes with, or limits, 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 member with longstanding deficits who does not experience any acute changes in their status and has previously met the criteria stated above regarding Level of Care Utilization System scores, but who now meets a level of care of two or lower on the Level of Care Utilization System, and needs subsequent medically necessary services for stabilization and maintenance at a lower intensity, may continue to receive psychosocial rehabilitation services, if deemed medically necessary.

National consensus statement on recovery

Recovery is a journey of healing and transformation enabling a person to live a meaningful life in a community of their choice while striving to achieve their full potential. Ten components of recovery are as follows:

- Self-direction;
- Individualized and person centered;
- Empowerment;
- Holistic;
- Non-linear;
- Strengths-based;
- Peer support;
- Respect;
- Responsibility; and
- Hope.

Assessment for psychosocial rehabilitation

- Each member must be assessed and must have a treatment plan developed based on that assessment;

- Assessments must be performed by a licensed mental health provider, and for children and adolescents must be completed with the involvement of the primary caregiver;
- For adult members, assessments must be performed prior to receiving psychosocial rehabilitation services and at least once every 365 days until discharge. Assessments must also be performed any time there is a significant change to the member's circumstances. See Appendix 2 for vocational and employment considerations; and
- For youth, assessments must be performed prior to receiving psychosocial rehabilitation services and at least once every 180 days until discharge. Assessments must also be performed any time there is a significant change to the member's circumstances. For additional details regarding conducting assessments for members six to 20 years of age, refer to Appendix 1.

Treatment plan development for psychosocial rehabilitation

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

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

- 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 adolescent and adult members in the setting of their 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 or Level of Care Utilization System rating, and other standardized assessment tools as clinically indicated (See Appendix 1);
- 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 licensed mental health provider must review the treatment plan including the goals, objectives, interventions, places of service, and service participants to ensure each service contact increases the possibility that a member will make progress. To determine if updates are needed, the review must be in consultation with provider staff, the member/caregiver, and other stakeholders at least once every 180 days or more often if indicated. The member record must include documentation of the treatment plan review.

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

Monitoring member progress

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

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

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

Documentation

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

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

Service utilization

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

Services provided to child and adolescent members 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/adolescent member's medical record.

Determine the appropriate services and level of intensity

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

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

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

Service delivery

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

- 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 AmeriHealth Caritas.

Active intervention vs. observation

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

Service location

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

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

The following are required when services are delivered at school:

- The initial and ongoing assessment must indicate school related needs, which may include, but is not limited to, disruptive behaviors in school, poor school attendance, and difficulties with social and peer interactions in school;
- Prior to mental health rehabilitation services being delivered in the school setting, each member must be assessed by a licensed mental health provider. This assessment must include a review of school records and interviews with school personnel. Ongoing reassessment of need must be conducted by a licensed mental health provider to determine if services must continue with school as a place of service;
- Mental health rehabilitation providers must collaborate with school personnel to collect data to monitor a member's progress. Data collection may include standardized tools as well as collecting other information to determine if a member is making progress. This must be documented in the member's record;
- The member must not be removed from a core class such as math, science, or English, without written permission from the parent and school personnel. A rationale must be documented in the member's record. If allowed by the member's school, direct interventions may be delivered in the classroom if medically necessary and on the member's treatment plan;
- Prior to delivering services in a member's school, the provider must obtain written approval from the school. The written approval must be filed in the member's record; and
- Providers delivering services in a member's school must actively communicate and coordinate services with school personnel and with the member's family/caregiver to avoid service duplication.

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

Providers must accurately identify and report on each claim where a service took place using the most appropriate Centers for Medicare & Medicaid Services place of service code.

Delivering services to family members

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

- 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; and
- Fourth-degree relatives include great-great grandparents, great-great grandchildren, and children of first cousins.

Member choice form and process

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

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

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

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

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

Limitations/exclusions

The following services are not medically necessary:

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

The following activities are not considered psychosocial rehabilitation services, including permanent supportive housing, and are, therefore, not medically necessary as psychosocial rehabilitation services:

- Activities provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide, or an academic tutor;

- Child care provided as a substitute for the parent or other individuals responsible for providing care and supervision;
- Respite care;
- Teaching job related skills (management of symptoms and appropriate work habits may be taught);
- Vocational rehabilitation (vocational assessment, job development, job coaching); psychosocial rehabilitation services can include services, such as interpersonal skills, anger management, etc.) that enable the member to function in the workplace;
- Transportation;
- Staff training;
- Phone contacts including attempts to reach the member by telephone to schedule, confirm, or cancel appointments;
- Staff supervision;
- Completion of paper work when the member and/or their significant others are not present. Requiring members to be present only for documentation purposes is not reimbursable;
- Team meetings and collaboration exclusively with staff employed or contracted by the provider where the member and/or their family/caregivers are not present;
- Observation of the member (e.g., in the school setting or classroom);
- Staff research on behalf of the member;
- Summer camps set up and billed the time as a mental health rehabilitation service;
- Indirect costs such as all contacts by salaried professionals (e.g., supervisors, administrators, human resources staff, receptionists, etc.) that are included in the rate (including meetings, travel time, etc.);
- Contacts that are not medically necessary;
- Medically necessary services that have not been rendered;
- Services rendered that are not in accordance with an approved authorization;
- Interventions not identified in the member's treatment plan;
- Services provided to children, spouse, parents, or siblings of the eligible member under treatment or others in the eligible member's life to address problems not directly related to the eligible member's issues and not listed on the member's treatment plan;
- Services provided that are not within the provider's scope of practice;
- Any art, movement, dance, or drama therapies; and
- Any intervention or contact not documented.

Provider responsibilities

- All services must be delivered in accordance with federal and state laws and regulations, the provider manual and other notices or directives issued by the Plan. The provider must create and maintain documents to substantiate that all requirements are met;

- The provider must ensure no staff is providing unsupervised direct care prior to obtaining the results of the statewide criminal background check and addressing the results of the background check, if applicable;
- Any licensed practitioner providing mental health services must operate within their scope of practice license; and
- Psychosocial rehabilitation services provided by staff (holding an individual National Provider Identifier) regardless of employment at multiple agencies must be limited to a maximum combined total of twelve (12) reimbursable hours of psychosocial rehabilitation services within a calendar day:
    - The twelve-(12) hour limitation must not apply per individual behavioral health services provider agency, rather it applies per individual rendering provider;
    - The twelve-(12) hour limitation must not apply to evidence-based practices; and
- There is a maximum combined total of twelve (12) reimbursable hours of psychosocial rehabilitation services unless any of the following conditions are met:
    - The medical necessity of the services is documented through the prior authorization approval for a member receiving more than twelve (12) hours of psychosocial rehabilitation services;
    - The services are billed for a group setting and the total hours worked by an individual rendering provider does not exceed twelve (12) hours per calendar day; or
    - The services are billed for crisis intervention.

Core services

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

- Assessment;
- Orientation;
- Treatment;
- Client education;
- Consultation with professionals;
- Counseling services;
- Referral;
- Rehabilitation services;
- Crisis mitigation services; and
- Medication management.

Exception: Behavioral Health Service Providers exclusively providing the evidence-based practice Functional Family Therapy (FFT/FFTCW), Homebuilders® or Multi-Systemic Therapy are excluded from the requirement to provide medication management.

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

The Behavioral Health Service Provider's crisis mitigation plan must include the following:

- Identify steps to take when a member suffers from a medical, psychiatric, medication or relapse crisis; and
- Specify names and telephone numbers of staff or contracted entities to assist members in crisis.

If the Behavioral Health Service Provider contracts with another entity to provide crisis mitigation services, the Behavioral Health Service Provider must have a written contract with the entity provided the crisis mitigation services.

The qualified individual, whether contracted or employed by the Behavioral Health Service Provider, must call the member within 30 minutes of receiving notice of the member's call.

Core staffing

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

The minimum core staffing requirements are:

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

Medical director

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

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

The medical director has the following assigned responsibilities:

- Ensures that necessary medical services are provided that meet the needs of the members;
- Provides oversight for provider policy/procedure, member treatment plans, and staff regarding the medical needs of the members according to the current standards of medical practice;

- Directs the specific course of medical treatment for all members;
- Reviews reports of all medically related accidents/incidents occurring on the premises and identifies hazards to the administrator;
- Participates in the development and implementation of policies and procedures for the delivery of services;
- Periodically reviews delivery of services to ensure care meets the current standards of practice; and
- Participates in the development of new programs and modifications.

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

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

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

Clinical director

A clinical director who, for those Behavioral Health Service Providers, which exclusively provide the evidence-based practice Functional Family Therapy (FFT/FFTCW), Homebuilders, or Multi-Systemic Therapy must:

- Be a licensed psychiatrist, licensed psychologist, licensed clinical social worker, licensed professional counselor, or licensed marriage and family therapist with a minimum of two years qualifying experience in treating psychiatric disorders and who maintains a current, unrestricted license to practice in the state of Louisiana;
- Have the following assigned responsibilities:
    - Ensures that the necessary services are provided to meet the needs of the members;
    - Provides oversight for the provider policy/procedure, treatment planning, and staff regarding the clinical needs of the members according to the current standards of clinical practice;
    - Directs the course of clinical treatment for all members;
    - Reviews reports of all accidents/incidents occurring on the premises and identifies hazards to the Administrator;
    - Participates in the development and implementation of policies and procedures for the delivery of services;
    - Periodically reviews delivery of services to ensure care meets the current standards of practice; and
    - Participates in the development of new programs and modifications.
- Have the following responsibilities or designates the duties to a qualified practitioner:

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

Administrator

An administrator must:

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

Clinical supervisor

A clinical supervisor must:

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

Mental health supervisor

As required pursuant to La. R.S. 40:2162, et seq., a mental health supervisor who, for those Behavioral Health Service Providers who provide psychosocial rehabilitation services, must:

- Be a fully licensed physician, or currently licensed and in good standing in the state of Louisiana to practice within the scope of all applicable state laws, practice acts, and the individual's professional license, as one of the following:
  - Medical psychologist;

- Licensed psychologist;
- Licensed clinical social worker;
- Licensed professional counselor;
- Licensed marriage and family therapist; or
- Licensed advanced practice registered nurse in adult psychiatric and mental health, and family psychiatric and mental health, or certified nurse specialists in psychosocial, gerontological psychiatric mental health, adult psychiatric and mental health and child-adolescent mental health.

- Be employed by the Behavioral Health Service Provider for at least 35 hours per week; and
- Assist in the design and evaluation of treatment plans for psychosocial rehabilitation services.

Nursing staff

Nursing staff must:

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

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

Staff supervision for non-licensed staff

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

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

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

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

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

The licensed mental health provider (excluding Licensed Addiction Counselors) supervisor must ensure services are in compliance with the established and approved treatment plan.

Group supervision means one licensed mental health provider supervisor (excluding Licensed Addiction Counselors) and not more than six (6) supervisees in supervision session.

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

The supervision with the licensed mental health provider must:

1. Occur before initial services on a new member begin and, at a minimum, twice a month preferably every fifteen (15) days (except under extenuating or emergent circumstances that are reflected in the supervisory notes);
2. Progress notes that are discussed in supervision must have the licensed mental health provider supervisor signature; and
3. Have documentation reflecting the content of the training and/or clinical guidance. The documentation must include the following:
    a. Date and duration of supervision;
    b. Identification of supervision type as individual or group supervision;
    c. Name and licensure credentials of the licensed mental health provider supervisor;
    d. Name and credentials (provisionally licensed, master's degree, bachelor's degree, or high school degree) of the supervisees;
    e. The focus of the session and subsequent actions that the supervisee must take;
    f. Date and signature of the licensed mental health provider supervisor;
    g. Date and signature of the supervisees;
    h. Member identifier, service and date range of cases reviewed; and
    i. Start and end time of each supervision session.

Alternative covered services

None identified

References

Louisiana Department of Health. Behavioral Health Services Provider Manual. Section 2.3 Outpatient services. Mental health rehabilitation services. https://www.lamedicaid.com/provweb1/providermanuals/manuals/bhs/bhs.pdf. Published March 14, 2017. Issued January 12, 2024

Policy updates

Initial review date: 3/1/2021

8/2022: Policy references added.

04/2023: Additional language added to Policy Statement section.

5/2024: Criteria added to the coverage section.

Appendix 1.

Standardized assessments for members receiving psychosocial rehabilitation

All mental health rehabilitation providers are required to implement the statewide use of the Child and Adolescent Level of Care Utilization System and the Level of Care Utilization System for members receiving community psychiatric support and/or psychosocial rehabilitation between the ages of six through 20 years of age. The Child and Adolescent Level of Care Utilization System is not required for members under the age of six years of age. For members 21 years of age and older, there are no changes in the administration of the Level of Care Utilization System for this age group.

Members six -18 years of age

Members receiving psychosocial rehabilitation, ages six through 18 years of age, must be assessed using the Child and Adolescent Level of Care Utilization System.

Members 19 - 20 years of age

Members receiving psychosocial rehabilitation, ages 19 through 20 years of age, must be assessed using the Level of Care Utilization System.

Members enrolled in the Coordinated System of Care

For members who are enrolled in the Coordinated System of Care and are receiving psychosocial rehabilitation, mental health rehabilitation providers are only required to complete the Child and Adolescent Level of Care Utilization System/Level of Care Utilization System at discharge from the Coordinated System of Care program. The Coordinated System of Care contractor will include the discharge rating in the Coordinated System of Care packet submitted to the member's managed care organization. The next rating will be due six months following this rating. If the discharge packet does not include a Child and Adolescent Level of Care Utilization System/Level of Care Utilization System discharge rating, the mental health rehabilitation provider will be required to conduct a rating within 30 calendar days following the transition back to the member's managed care organization for psychosocial rehabilitation services to continue.

The following applies to members between the ages of 6 through 20 years of age enrolled in a managed care organization.

Conducting the Child and Adolescent Level of Care Utilization System/Level of Care Utilization System rating

The assessment and rating must be conducted face-to-face with the member and shall be completed with the involvement of the primary caregiver as well as with other natural supports if necessary. The assessment shall be conducted in a culturally and linguistically competent manner. The rating shall be part of a full psychosocial/psychiatric assessment.

Documentation

Mental health rehabilitation providers must use assessment forms that collect all data elements necessary to rate the Child and Adolescent Level of Care Utilization System. The Level of Care Utilization System assessment form currently being used for members 21 years of age and older must be used for members 19-20 years of age. Providers must also submit Child and Adolescent Level of Care Utilization System/Level of Care Utilization System ratings on a form that includes the rating in each dimension, the criteria to support the rating, independent criteria, the composite score, the level of care, a section to document notes, a signature line with credentials, and a rating date. A sample rating form is on page 48 of the Child and Adolescent Level of Care Utilization System manual.

Frequency of use

A Child and Adolescent Level of Care Utilization System/Level of Care Utilization System rating must be completed and submitted for all members prior to receiving psychosocial rehabilitation as part of the initial comprehensive assessment and every 180 days thereafter until discharge. The last Child and Adolescent Level of Care Utilization System/Level of Care Utilization System rating shall be administered at discharge and submitted to the member's managed care organization. In the event a member is not available to conduct a final rating upon discharge, the provider should make a note in the member's record and notify the member's managed care organization or the Coordinated System of Care contractor. For the discharge rating, a comprehensive assessment is not required. The rating should be part of the member's discharge summary and may be completed during an individual therapy session, or while delivering community psychiatric support and treatment. A psychiatric diagnostic evaluation (90791) is limited to one every six months or two per year. Therefore, it should not be used for the discharge rating.

The managed care organization may request a reassessment when a member transfers from one mental health rehabilitation provider to another mental health rehabilitation provider if there has been a clinical change that may necessitate an updated rating or if there is a gap in services within six months and an updated rating is needed. Upon such a transfer, the managed care organization will make available to the new provider the previous Child and Adolescent Level of Care Utilization System/Level of Care Utilization System data if the previous provider does not have the information. There is an exception for members enrolled with Louisiana Healthcare Connections. The new provider who is unable to obtain the records from the previous provider should conduct an assessment and Child and Adolescent Level of Care Utilization System/Level of Care Utilization System rating instead of requesting the records from Louisiana Healthcare Connections.

Staff level

The Child and Adolescent Level of Care Utilization System/Level of Care Utilization System must be conducted and rated by a physician or licensed mental health practitioner who has successfully completed the required training. A licensed mental health practitioner 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. A licensed mental health practitioner includes the following individuals licensed to practice independently:

- **Medical psychologist;**
- **Licensed psychologist;**
- **Licensed clinical social worker;**

- **Licensed professional counselor;**
- **Licensed marriage and family therapist;**
- **Licensed addiction counselor; and**
- **Advanced practice registered nurse.**

Advanced practice registered nurses must be nurse practitioner specialists in adult psychiatric and mental health as well as in family psychiatric and mental health or they must be certified nurse specialists in psychosocial, gerontological psychiatric mental health, adult psychiatric and mental health, and child-adolescent mental health. They may practice to the extent that services are within the advanced practice registered nurse's scope of practice.

Training

Physicians and licensed mental health professional staff assessing members using the Child and Adolescent Level of Care Utilization System/Level of Care Utilization System must complete training prior to conducting their first rating. The managed care organizations and the Coordinated System of Care contractor must require physicians and licensed mental health professional staff conducting Child and Adolescent Level of Care Utilization System/Level of Care Utilization System ratings to repeat the training if ratings are inconsistent with the clinical information submitted with the rating. Managed care organizations and the Coordinated System of Care contractor shall ensure mental health rehabilitation providers have access to training for all physicians and licensed mental health professional staff.

Managed care organization use of Child and Adolescent Level of Care Utilization System/Level of Care Utilization System data

Child and Adolescent Level of Care Utilization System/Level of Care Utilization System data including the rating for each dimension, the final score and level of care, psychosocial and psychiatric assessments, treatment history, other standardized assessment tools, and treatment plans shall be used to determine eligibility, frequency and duration for psychosocial rehabilitation. Other useful sources of information that a provider may submit include data from school, other mental health or substance use providers, etc.

A member's final score/level of care, or a rating in one or more dimensions on the Child and Adolescent Level of Care Utilization System/Level of Care Utilization System, should not be used as the only data element to determine who may be eligible or should continue to receive psychosocial rehabilitation. A member's rating shall also not be used as the only factor to determine a service authorization, using a pre-established set of services and number of units for a duration of time, based on the results of a member's Child and Adolescent Level of Care Utilization System/Level of Care Utilization System rating.

Exceptions

Members who receive Multi-Systemic Therapy, Homebuilders, Functional Family Therapy and Functional Family Therapy-Child Welfare are not required to be assessed using the Child and Adolescent Level of Care Utilization System.

Appendix 2.

Employment supports for members receiving psychosocial rehabilitation

All mental health rehabilitation providers are encouraged to assess the need and implement appropriate services to support a member's employment goals within the context of psychosocial rehabilitation as appropriate for the members they serve. Psychosocial rehabilitation could be utilized to prepare for or in a workplace environment with a focus on helping a person overcome/address psychiatric symptoms or to develop and/or build a skill set that interfere with seeking, obtaining, or maintaining employment. Reimbursement for psychosocial rehabilitation includes employment supports if the services being provided are focused on illness management and recovery regardless of setting.

The licensed mental health professional should assess the perceived and/or actual barriers that are impeding a member's employment success, and treatment plans should address a member's interest/desire to work or pursue a career. Documentation should refer to the member's diagnoses, employment goals, and why assistance is needed due to psychiatric symptoms interfering with achieving employment goals.

Employment supports in psychosocial rehabilitation treatment plans

- **Teaching the member illness management and emotional regulation skills in the context of employment, both on and off the job;**
- **Teaching the member how to focus on reframing and ordering tasks when symptoms present barriers to working;**
- **Teaching the member to improve sleep hygiene and daily living activities to enhance their effectiveness in job seeking and keeping;**
- **Problem solving with the member as they are contemplating employment by providing structured interviewing about the member's skills, abilities, wishes, and experiences in the area of employment;**
- **Role playing with the member when they are planning interviews with potential employers to use illness management and emotional regulation skills;**
- **Teaching assertiveness training and other interpersonal communication skills in the employment setting;**
- **Building communications skills to learn to interact with employers/co-workers;**
- **Building skills related to personal hygiene and dress and presenting oneself for job interviews/work;**
- **Develop/improve time management skills to include areas specific to work schedules arriving to work when scheduled and timely;**
- **Learning appropriate work habits-appropriate topics and behavior when in a work environment;**
- **Skills building as it relates to where to go to look for a job, how to complete job application, etc.; and**
- **Advocating for self in the work place (asking for a raise, time off, etc.).**

Exclusions

The following employment supports are not medically necessary in the mental health rehabilitation program:

- **Skills training related to a specific job (how to operate equipment, use computer programs. fill customer orders, etc.);**
- **Staff presence in the workplace to assist with supervision or teaching of routine work duties;**
- **Approaching potential employers to "job develop" without the member present; and**
- **Presentations to the business community to seek partnerships in hiring.**

Note to assertive community treatment providers:

This guidance does not limit the tasks performed by the employment specialists within the assertive community treatment service. Assertive community treatment providers should render employment support in accordance with the assertive community treatment model.