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Aetna Better Health® of Louisiana

Appendix B: Behavioral Health

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Section 1: Behavioral Health Overview, Criteria, and Limitations

Behavioral health is defined as those services provided for the assessment and treatment of problems related to mental health and substance use disorders. Substance use disorders include abuse of alcohol and other drugs. In order to meet the behavioral health needs of our members, Aetna Better Health of Louisiana will provide a continuum of services to members at risk of or suffering from mental, addictive, or other behavioral disorders. We are an experienced behavioral health care organization and have contracted with behavioral health providers who are experienced in providing behavioral health services to the Louisiana population.

Specialized Behavioral health services is a covered benefit for Aetna Better Health members. Additional benefits may be available for ABHLA members for those who qualify. Providers can call the toll-free number located on the back of the member's identification card to access information about services, participating behavioral health providers and authorization information for members who request services from a behavioral health provider directly.

In addition, for all categories of members, Aetna Better Health of Louisiana will cover the diagnoses of diseases of organic origin categorized as altering the mental status of a member.

Aetna Better Health of Louisiana's Chronic Care Management Program ICM Objective:

- Provides an integrated approach to physical and behavioral health conditions, that also addresses psychosocial circumstances, is critical to help our most vulnerable and highest risk
    - Engages member and care providers to enhance care outcomes
    - Works as an interdisciplinary team that combines core competencies in physical and behavioral health within a systems framework to manage psycho-social complexity and challenging relationships with members and their families
- Focuses on member health and well-being using behavioral change strategies, relationship building and engaging community and social systems to wrap around the member to enhance resiliency and self-efficacy
- Starts with assessing members as they are identified, evaluating them as "whole" beings, and including all elements surrounding them that may impact their health status
- Assigns to an appropriate level of intervention intensity, and staff will team with them in managing their care
- Tools and services assist in decreasing the need for invasive care and increasing self-management to improve health and well-being
- Establish a collaborative working relationship with providers in each region of the state
- Identify strengths: Assure we neither duplicate nor disrupt what is working well
- Identify and prioritize gaps in the local array of services and supports each members needs and conditions in general and priority populations in particular
- Identify and respond to opportunities for training and technical assistance to support providers

Referrals

Members will be able to self-refer to any participating MH/SUD provider with our network without a referral from their Primary Care Provider (PCP). However, we promote early intervention and health screening for identification of behavioral health problems and patient education. To that end, Aetna Better Health of Louisiana providers are expected to:

- Screen, evaluate, treat, and refer (as medically appropriate), any behavioral health problem/disorder;
- Treat mental health and substance use disorders within the scope of their practice;
- Inform members how and where to obtain behavioral health services; and
- Understand that members may self-refer to an Aetna Better Health of Louisiana behavioral health care provider without a referral from the member's Primary Care Provider (PCP).

Mental Health Parity and Addition Equality Act (MHPAEA)

The Mental Health Parity and Addiction Equity Act (MHPAEA) was enacted to verify "parity" or fairness between mental health and substance use disorder (MH/SUD) benefits and medical/surgical benefits covered by a Managed Care Organization (MCO) such as Aetna Better Health of Louisiana. Enacted in 2008, MHPAEA does not require an (MOC) to offer MH/SUD benefits, but if the plan does so, it must offer the benefits on par with the other medical/surgical benefits it covers. In 2010, The Departments of Treasury, Labor, and Health and Human Services

issued Interim Final Regulations (IFR) implementing the law. On Friday November 8, 2013, the Departments issued a Final Rule (FR) implementing the law.

A simple example of a parity requirement would be the frequency of office visits. Under MHPAEA, a plan may not allow a patient to have an unlimited number of medically necessary appointments with a dermatologist, but limit patients to only 5 appointments with a psychiatrist. However, while the premise of the law seems simple, the regulations related to the law are quite complicated, and therefore, implementation of the law has been complicated. This brief summary of the law is intended to help providers understand the law and the rights it affords them.

Links to Key Materials

- Final regulation, available at **www.dol.gov/ebsa/pdf/mhpaeafinalrule.pdf**
- Interim Final Regulation, available at **www.dol.gov/ebsa/mentalhealthparity/**
- FAQs about ACA Implementation Part XVII and Mental Health Parity Implementation, available at **www.dol.gov/ebsa/faqs/faq-aca17.html**
- U.S. Department of Health and Human Services' Study: Consistency of Large Employer and Group Health Plan Benefits with Requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, available at **www.dol.gov/ebsa/pdf/hhswellstonedomenicimhpaealargeemployerandghpbconsistency.pdf**
- News release, available at **http://www.dol.gov/ebsa/newsroom/2013/13-2158-NAT.html**
- CMS January 16, 2013 letter to State Health Officials and Medicaid Directors, available at **www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf**
- CMS overview document **www.cms.gov/regulations-and-guidance/health-insurance-reform/healthinsreformforconsume/downloads/mhpaea.pdf**
- **www.aetnabetterhealth.com/louisiana/providers/index.html**

Section 2: Provider Requirements and Responsibilities

Approved Behavioral Health providers can be found on our website using the online provider search tool: **https://www.aetnabetterhealth.com/louisiana/find-provider.**

All providers (both facility and ordering physicians) must be registered in the state and the health plan's registry. The provider should be a preferred provider for the health plan.

For a further list of provider requirements, please see chapter 2 of the **LDH Medicaid Services Manual**.

Provider Network Monitoring Program

It is the policy of ABHLA to measure compliance with LDH Behavioral Health Provider Network Monitoring Standards. The Behavioral Health Provider Network Monitoring Process will aim to maintain a network of qualified providers through review, analysis, and evaluation of provider and staff personnel records and other administrative records.

ABHLA requires ongoing monitoring of provider qualifications and requirements of a representative sample size of all in-network Specialized Behavioral Health Service (SBHS) providers to ensure compliance with established state and federal guidelines and regulations.

- SBHS providers sampled with an overall score below 100% must be reported detailing deficiencies.
- SBHS providers sampled must meet 100% overall for provider qualifications and requirements or be subject to a corrective action plan.
- SBHS providers sampled have 15 days to correct identified deficiencies and submit documentation demonstrating compliance.
- Pursuant to LA R.S. 46:460.73, reimbursement for any services provided during the fifteen-day remedy period after notice of the deficiency was identified by ABHLA, or during a longer period if allowed by LDH, will be withheld if the provider elects to continue providing services while the deficiency is under review.
- If the deficiency is remedied, ABHLA will remit payment to the provider.
- If the deficiency is not remedied, nothing in this Subsection shall be construed to preclude ABHLA from recouping funds from the provider for any period in which the provider was not properly enrolled, credentialed, or accredited.
- Providers not demonstrating compliance after the **15 days period** will be referred for non-compliance to the appropriate department per ABHLA policies and procedures.
- Provider records are to be maintained in a manner that is current, detailed, organized, and which permits effective quality review.

The Provider Network Monitoring Review will include the following but is not limited to: requirements associated with licensure, accreditation, educational and professional experience, staffing requirements, and training as established by Medicaid provider policy manuals as well as accuracy of provider demographics associated with service location addresses, telephone numbers, languages spoken, current staff rosters and status of accepting new Medicaid referrals, as compared against ABHLA credentialing files and the ABHLA provider directory listings. Providers will be reviewed based on the services for which they have received reimbursement and no more than once within the calendar year, unless ABHLA has identified cause for a re-review.

Provider Assessments

On an annual basis, Aetna Better Health of Louisiana along with other Managed Care Organizations (MCOs) will conduct an assessment of practice integration using the Integrated Practice Assessment Tool (IPAT) on those providers who are likely to interface with the behavioral health populations.

Coordination Between Behavioral Health and Physical Health Services

We are committed to coordinating medical and behavioral care for members who will be appropriately screened, evaluated, treated, and referred for physical health, behavioral health. With the member's permission, our case management staff can facilitate coordination of case management related substance use screening and behavioral health evaluation, and treatment.

Members seen in the primary care setting may present with a behavioral health condition, which the PCP must be prepared to recognize. Primary Care Providers (PCPs) are encouraged to use behavioral health screening tools, treat behavioral health issues that are within their scope of practice and refer members to behavioral health providers when appropriate. Members seen by behavioral health providers are screened for co-existing medical issues. Behavioral health providers will refer members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the member's consent. Behavioral health providers may only provide physical health care services if they are licensed to do so. Mental Health/Substance use (MH/SUD) providers are asked to communicate any concerns regarding the member's medical condition to the PCP, with the members consent if required, and work collaboratively on a plan of care.

Information is shared between Aetna Better Health of Louisiana and participating behavioral health and medical providers to verify interactions with the member result in appropriate coordination between medical and behavioral health care.

The Primary Care Provider and behavioral health provider are asked to share pertinent history and test results within 24 hours of receipt of results in urgent or emergent cases, and notification within 10 business days of receipts o results for non-urgent or non-emergent lab results. Members will be able to self-refer to any participating MH/SUD provider with our network without a prior authorization or a referral from their PCP.

Routine, non-urgent, or preventative care visits shall be arranged within 6 weeks. For behavioral healthcare, routine, non-urgent appointments shall be arranged within fourteen (14) days of referral.

Medical Records Standards

Medical records must reflect all aspects of patient care, including ancillary services. Participating providers and other health care professionals agree to maintain medical records in a current, detailed, organized, and comprehensive manner in accordance with customary medical practice, applicable laws, and accreditation standards. Medical records must reflect all aspects of patient care, including ancillary services. Detailed information on Medical Records Standards can be found in Chapter 4 of the ABHLA Provider Manual under Medical Records Review.

Availability

Mental Health/Substance Use Disorder (MH/SUD) providers must be accessible to members, including telephone access, 24 hours a day, and 7 days per week in order to advise members requiring urgent or emergency services. If the MH/SUD provider is unavailable after hours or due to vacation, illness, or leave of absence, appropriate coverage with other participating providers must be arranged. Mental Health/Substance use disorder (MH/SUD) providers are required to meet our contractual standards for urgent, emergent and routine behavioral health appointments. For a complete list, please see Appointment Availability Standards in Chapter 4 of the main ABHLA Provider Manual.

Urgent and Emergent Care

Urgent Care providers must have availability within twenty-four (24) hours of member notification of the existence of an urgent condition. Provisions must be available for obtaining urgent care 24 hours per day, 7 days per week. Urgent care may be provided directly by the PCP or directed by the MCO through other arrangements. An appointment shall be arranged within forty-eight (48) hours of request.

Providers must deliver emergent or emergency visits immediately upon behavioral health member presentation at the service delivery site. Emergent, crisis or emergency behavioral health services must be available at all times and an appointment shall be arranged within one (1) hour of request.

For urgent non-emergency behavioral health care, providers must have availability with forty-eight (48) hours of member request.

Act 503: Community Psychiatric Support and Treatment and Psychosocial Rehabilitation Services

Act 503, effective January 1, 2023, revises components of community psychiatric support and treatment (CPST) and psychosocial rehabilitation (PSR) services and the staff able to provide such services. Act 503 defines "community psychiatric support and treatment services" as CMS-approved Medicaid mental health rehabilitation services designed to reduce disability from mental illness, restore functional skills of daily living, build natural supports, and achieve

identified person-centered goals or objectives through counseling, clinical psycho-education, and ongoing monitoring needs as set forth in an individualized treatment plan. “Psychosocial rehabilitation services” means CMS-approved Medicaid mental health rehabilitation services designed to assist the individual with compensating for or eliminating functional deficits and interpersonal or environmental barriers associated with mental illness through skill building and supportive interventions to restore and rehabilitate social and interpersonal skills and daily living skills.

Any individual rendering the assessment and treatment planning components of CPST services for a licensed and accredited provider agency shall be a fully licensed mental health professional. Any individual rendering any of the other components of CPST services for a licensed and accredited provider agency shall be a fully licensed mental health professional, a provisionally licensed professional counselor, a provisionally licensed marriage and family therapist, a licensed master social worker, a certified social worker, or a psychology intern from an American Psychological Association approved internship program.

Any individual rendering PSR services for a licensed and accredited provider agency will hold a minimum of one of the following:

- A bachelor’s degree from an accredited university or college in the field of counseling, social work, psychology, sociology, rehabilitation services, special education, early childhood education, secondary education, family and consumer sciences, criminal justice, or human growth and development;
- A bachelor’s degree from an accredited university or college with a minor in counseling, social work, sociology, or psychology; or
- Be twenty-one (21) years of age or older as of January 1, 2022, have a high school diploma or equivalent, and have been continuously employed by a licensed and accredited agency providing PSR services since prior to January 1, 2019.

Once Act 503 is implemented, only the above listed provider types can render and will be reimbursed for CPST and PSR services.

Section 3: Reimbursement Standards

All Behavioral Health services are reimbursed based on the Louisiana Department of Health (LDH) **Specialized Behavioral Health Services (SBHS) Fee Schedule**. For coverage criteria including member eligibility and prior authorization requirements, see the individual service listed in Section 5 of this Appendix.

Effective 8/1/2024, CMS approved for Medicaid reimbursement of services delivered by provisionally licensed counselors (PLPC), provisionally licensed marriage and family therapists (PLMFT), and licensed master social workers (LMSW). Allowable procedures and rates can be found on the SBHS fee schedule and **Informational Bulletin 24-25**.

Emergency Certificates for Inpatient or Residential Behavioral Health Services

Aetna Better Health of Louisiana is required to pay claims for behavioral health services provided to enrollees committed under an emergency certificate to an inpatient or residential facility regardless of medical necessity for a maximum period of 24 hours from the time of admission to the inpatient or residential facility, as long as the following conditions are met:

- The admitting physician and the evaluating psychiatrist or medical psychologist must offer the subject of the emergency certificate the opportunity for voluntary admission; and
- Any person committed under an emergency certificate must be evaluated by a psychiatrist or medical psychologist in the admitting facility within 24 hours of arrival at the admitting facility.

After the psychiatric evaluation has been completed, payment of claims must be determined by medical necessity. If the subject of the emergency certificate does not receive a psychiatric evaluation within the required timeframe, Aetna Better Health of Louisiana is only required to pay behavioral health claims within the first 24 hours of admission. Payment for any subsequent claim must be determined by medical necessity.

Section 4: Coverage Requirements

Per the Behavioral Health chapter of the LDH Medicaid Services Manual:

> All mental health services must be medically necessary in accordance with LAC 50:I.1101. The medical necessity for services shall be determined by a licensed mental health professional (LMHP) or physician who is acting within the scope of their professional license and applicable state law. There shall be member involvement throughout the planning and delivery of services. Services shall be:
>
> 1. Delivered in a culturally and linguistically competent manner;
> 2. Respectful of the individual receiving services;
> 3. Appropriate to individuals of diverse racial, ethnic, religious, sexual and gender identities and other cultural and linguistic groups; and
> 4. Appropriate for age, development; and education

Section 5: Covered Services

This appendix includes a list of services and products covered under the Specialized Behavioral Health Services. For a full list of covered services and administrative procedures, please see the **ABHLA Provider Manual**. For a full list of member assessment criteria and provider and facility requirements, please see chapter 2 of the **LDH Medicaid Services Manual.**

Addiction Services

Addiction services include outpatient, intensive outpatient, inpatient, and residential services designed to help members recover from a variety of substance use disorders. PA is required.

The following American Society of Addiction Medicine (ASAM) levels are covered. Specific information and provider criteria can be found in the **LDH Medicaid Services Manual**:

- Level 1.5: Outpatient
- Level 2.1: Intensive outpatient
- Level 2.7: Medically managed intensive outpatient
- Level 3.1: Clinically managed low-intensity residential treatment-adolescent & adult
- Level 3.5: Clinically managed medium intensity residential treatment – adolescent
- Level 3.5: Clinically managed high intensity residential treatment –adult
- Level 3.7: Medically managed residential treatment
- Level 3.7: Medically monitored intensive inpatient treatment – adolescent (PRTF) (Refer to the Psychiatric Residential Treatment Facilities (PRTF) Section for definition, qualifications, and requirements)
- Level 3.7-WM: Medically managed residential withdrawal management-adult (residential setting)
- Level 4: Medically managed inpatient (hospital)

Applied Behavior Analysis (ABA)

ABA therapy is available to members under the age of 21 and requires PA. Members must meet all of the following criteria:

1. Exhibit the presence of excesses and/or deficits of behaviors that significantly interfere with home or community activities (e.g., aggression, self-injury, elopement, etc.);
2. Have been diagnosed with a condition for which ABA-based therapy services are recognized as therapeutically appropriate, including autism spectrum disorder, by a qualified health care professional;
3. Had a comprehensive diagnostic evaluation by a qualified health care professional; and
4. Have a prescription for ABA-based therapy services ordered by a qualified health care professional.

Services must be medically necessary and provided by (or under supervision of) a licensed behavior analyst. Licensed psychologist, or licensed medical psychologist.

Medical necessity is determined based on a comprehensive diagnostic evaluation performed by a qualified health care professional (QHCP). QHCPs include Pediatricians using the MCHAT-R/F, and clinical judgment may diagnosis and complete a comprehensive diagnostic evaluation. For children who receive a high-risk score of ≥ 8 on the MCHATR/F, pediatricians can independently make a diagnosis of autism (if their clinical judgment concurs with this score). For children who receive a moderate risk score of 3 to 7 on the MCHAT-R/F, pediatricians can complete the MCHAT-R/F follow-up interview, and based on their confidence in their clinical judgment, either independently make a diagnosis of autism or refer to a subspecialist listed below:

1. Pediatric neurologist;
2. Developmental pediatrician;
3. Psychologist (including a medical psychologist);
4. Psychiatrist (particularly pediatric and child psychiatrist);
5. Pediatrician under a joint working agreement with an interdisciplinary team of providers who are qualified to diagnose developmental disabilities;

6. Nurse practitioner (NP) practicing under the supervision of a pediatric neurologist developmental pediatrician, psychologist, or psychiatrist; or
7. Licensed individual, including speech and language pathologist, licensed clinical social worker (LCSW), or licensed professional counselor (LPC), who meets the requirements of and qualify as a QHCP when:
    a. Individual's scope of practice includes a differential diagnosis of Autism Spectrum Disorder (ASD) and comorbid disorders for the age and/or cognitive level of the beneficiary;
    b. Individual has at least two years of experience providing such diagnostic assessments and treatments or is being supervised by someone who is listed as a QHCP under 1-5 above; and
    c. If the licensed individual is working under the supervision of a QHCP, the QHCP must sign off on the CDE as having reviewed the document and being in agreement with the diagnosis and recommendation.

The CDE must include:

1. Thorough clinical history with the informed parent/caregiver, inclusive of developmental and psychosocial history;
2. Direct observation of the beneficiary, to include but not be limited to, assessment of current functioning in the areas of social and communicative behaviors and play or peer interactive behaviors;
3. Review of available records;
4. Valid Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5), or current edition, diagnosis;
5. Justification/rationale for referral/non-referral for an ABA functional assessment and possible ABA services; and 6. Recommendations for any additional treatment, care or services, specialty medical or behavioral referrals, specialty consultations, and/or any additional recommended standardized measures, labs or other diagnostic evaluations considered clinically appropriate and/or medically necessary.

Additional program and provider requirements can be found in the **Applied Behavior Analysis chapter** of the LDH Medicaid Service Manual.

Assertive Community Treatment (ACT) Services
Policy 7100.35

ACT services are covered for members aged 18 or older who have a severe and persistent mental illness (SPMI) and members with co-occurring disorders that seriously impair their functioning in the community.

PA is required and can be authorized for up to six (6) months. A comprehensive person-centered needs assessment must be completed within thirty (30) days of admission to the program.

For a full list of assessment criteria, qualifying conditions, and provider requirements, please see the above linked policy.

Basic Behavioral Health Services
Basic behavioral health services are provided in a primary care clinic and include screenings for mental health and substance use issues, prevention, early intervention, medication management, treatment, and referral to specialty services. These services are not limited by ABHLA.

Behavioral Health Home and Community Based Services for Adults
Services are covered for members eligible for adult mental health rehabilitation services. Prior authorization is required except when the case requires emergent crisis intervention.

Home and Community Based Services are assistance and support provided at home, school, or work. Additional services may be available for members with special mental health care needs. Services includes Assertive Community Treatment (ACT), Crisis Intervention (CI), Community Psychiatric Support and Treatment (CPST), and Psychosocial Rehabilitation (PSR).

Behavioral Health Home and Community Based Services for Children and Adolescents
Services are covered for members aged 0-20. The age for specific services varies. Prior authorization is required except when the case requires emergent crisis intervention.

Home and Community Based Services are assistance and support provided at home, school, or work. Additional services may be available for members with special mental health care needs. Services include Assertive Community Treatment (ACT), Crisis Intervention (CI), Functional Family Therapy (FFT), Homebuilders, Multi-systemic Therapy (MST), Community Psychiatric Support and Treatment (CPST), and Psychosocial Rehabilitation (PSR).

Behavioral Health In Lieu of (ILO) Services

In Lieu of (ILO) Service	Medicaid State Plan services(s)
23-Hour observation bed services for adult age 21 and older to allow for assessment to decide need for admission.	Inpatient Psychiatric Hospitals
Free standing psychiatric hospitals for adults ages 21-64 creates treatment beds outside the hospital and is less costly.	General Hospital Psychiatric units
Injection services provided by a licensed nurse to adults ages 21 and older for psychotropics medication to ensure compliance and stability.	Physician Services
Mental Health Intensive Outpatient Programs (IOP) to provide treatment in the least restrictive level of care, allowing an alternative to Inpatient hospitalization or Assertive Community Treatment and providing a step-down option from inpatient hospitalization for members at high risk for readmission	Inpatient Psychiatric Hospitals
Population Health Management Program (PHMP) targets, engages, and serves enrollees with SMI, SUD, and/or other comorbid medical conditions through team-based, tech-enabled, care extension services.	Emergency services, inpatient hospitals
Therapeutic day center for ages 5-20 provide intensive mental health supports to reduce incidents of crisis hospitalization and residential psychiatric care. (See Below)	Inpatient Psychiatric Hospitals and Psychiatric Residential Treatment Facilities

Mental Health Intensive Outpatient Services (MH IOP)
Policy 7500.75

For members aged 12 and over, ABHLA covers Mental Health Intensive Outpatient (MH IOP) services as in in lieu of benefit, which are psychiatric intensive outpatient services provided for a minimum of 6 hours per week for adolescents and 9 hours per week for adults. MH IOP is a psychiatric hospital-based service, and providers must follow the guidelines listed in the LDH Hospital Services Provider Manual (Chapter 25 of the Medicaid Services Manual). There is a 10:1 ratio for therapy groups and the treatment team should have a licensed mental health provider (LMHP), psychiatrist, and nurse on staff. All members are seen a minimum of monthly by the LMHP or psychiatrist but are seen more frequently as needed for medication changes or increased symptoms. Staff working with adolescent members (aged 12-17) must have received training specific to that population, incorporate family therapy and age-appropriate evidence-based practices into their treatment plan, and allow members to participate in school.

PA is required, and services can be approved for up to 30 days at a time.

Population Health Management Program (PHMP)
Mindoula Clinical Services' Population Health Management Program (PHMP) is a precision solution that targets, engages, and serves enrollees with Serious Mental Illness (SMI), Substance Use Disorder (SUD) and/or other comorbid medical conditions through team-based, tech-enabled, care extension services. This focused approach includes (1) identification of enrollees for the PHMP (2) outreach and enrollment of enrollees using an intake process specific to

SMI and SUD populations, and (3) provision of tech-enabled programmatic interventions that include content and methods tailored to reducing total costs of care by addressing behavioral, medical, and social needs specific to SMI and SUD populations. These interventions are designed to enhance participants' skills, strategies, and supports, which in turn help to prevent and reduce unnecessary and avoidable medical costs associated with SMI and/or SUD and other comorbid medical conditions, during the program and even after its completion. Members who are part of the follow-up after hospitalization for mental illness (FUH) and/or follow-up after emergency department (ED) visit for mental illness (FUM) populations who are not engaged in the Aetna Better Health case management program are eligible to participate in the program.

Therapeutic Day Center (ILO)
The Center for Resilience is a therapeutic day center in New Orleans which provides educational and intensive mental health supports to children and youth ages 5-20 in an innovative partnership with the Tulane University Medical School Department of Child and Adolescent Psychiatry to ensure the emotional well-being and academic readiness of children with behavioral health needs. Children receive instructional, medical, and therapeutic services at the day program site with the goal of building the skills necessary to successfully transition back to the traditional school setting. Center for Resilience provides a caring, non-punitive, therapeutic milieu with positive behavioral supports, trauma-informed approaches, evidence-based mental health practices, small-group classroom instruction, and therapeutic recreation activities.

PA is required.

Behavioral Health Services in a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC)
Behavioral health services rendered in FQHCs or RHCs are covered for all members who meet medical necessity criteria for the service received. PA requirements are based on the service rendered.

FQHCs must be certified by the federal government, and RHCs must be licensed by LDH. Providers rendering service must meet licensing requirements and qualifications of their given specialty.

Community Brief Crisis Support (CBCS) and Behavioral Health Crisis Care (BHCC) Services
Policy 7000.82

Community Brief Crisis Support (CBCS) requires prior authorization beyond the first sixteen (16) units of service, 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 (up to 15 days), or until the member can access alternative behavioral health supports and services. The member's treatment record must reflect relief, resolution and problem solving of the identified crisis or referral to an alternate provider. Additional units may be approved with prior authorization.

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 MCEs, Mobile Crisis Response (MCR), Behavioral Health Crisis Care (BHCC), or Crisis Stabilization (CS) providers as needed for ongoing follow up and care.

BHCC services are an initial or emergent psychiatric crisis response 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 ABHLA when a member presents. BHCC is intended to provide crisis supports and services during the first twenty-three (23) hours of a crisis. If the referral is made from CBCS to BHCC, prior authorization is required.

CBCS is covered for all ages, and BHCC is covered for members aged 21 and older when medically necessary. See the above linked policy for additional details.

Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR) Services
Policy 7100.50

CPST/PSR services are covered for members of all ages with significant functional impairments resulting from an identified mental health disorder diagnosis. PA is required for initial and follow-up services.

While a child/adolescent is receiving rehabilitation services, a parent/caregiver and necessary family members should be involved in medically necessary services. The treatment plan and progress notes must indicate the member's parent/caregiver and family are involved in treatment.

CPST/PSR requires member assessment and a resulting treatment plan. Assessments must be performed by an LMHP, and for children and adolescents will be completed with the involvement of the primary caregiver. Providers are required to use the Child Adolescent Level of Care Utilization System (**CALOCUS**) for members ages 6-18 receiving CPST and/or PSR and the Level of Care Utilization System (**LOCUS**) for members ages 19 and older receiving CPST and/or PSR. The CALOCUS is not required for members under the age of 6 years of age.

For adults, assessments must be performed prior to receiving CPST and/or PSR and at least once every 365 days until discharge. For youth, assessments must be performed prior to receiving CPST and/or PSR and at least once every 180 days until discharge. Assessments must also be performed any time there is a significant change to the member's circumstances. For members ages 6-20, a CALOCUS/LOCUS rating must be completed and submitted every 180 days until discharge.

For additional information, including further assessment requirements, medical necessity criteria, and exclusions and limitations, please see the above linked policy.

Coordinated Systems of Care

Members age 5-20 who have severe emotional disturbance or a serious mental illness and who are at risk of out of home placement are eligible to be enrolled in the Coordinated System of Care. Services include parent support and training, youth support and training, short-term respite care, and independent living/skill building. For more information, visit **www.csoc.la.gov**.

Crisis Intervention (CI)

Policy 7100.31

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. 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.

Emergent CI does not require PA but does require notification and authorization within one (1) business day of the start of services. Service is authorized for up to 24 hours per episode.

Ongoing CI is authorized for up to sixty-six (66) hours per authorization until the crisis is resolved not to exceed fourteen (14) days.

Requests beyond the above noted limitations can be authorized with medical director review. For more criteria, please see the above linked policy or the **LDH Medicaid Services Manual**.

Crisis Response Services (CRS)

Crisis resolution and support are provided in a community setting and available upon request twenty-four hours a day, seven days a week. Services include Mobile Crisis Response (MCR), Behavioral Health Crisis Care (BHCC), and Community Brief Crisis Support (CBCS). All services require a patient follow-up within 24 hours of services rendered.

While MCR and CBCS are covered for members of all ages, BHCC is only covered for members aged 21 and over. PA is required for CBCS.

Crisis Stabilization (CS) for Adults

Policy 7000.54

Crisis Stabilization (CS) for adults consists of short term, intensive, bed-based crisis support. Members admitted to this level of care should be medically stable. Members who have co-morbid physical conditions that require nursing or hospital levels of care or who are a threat to themselves or others and require an inpatient level of care are not eligible.

Components of CS include assessment, intervention, care coordination, and follow-up. For details on these components, please see the above linked policy.

Referrals for CS must be made by Mobile Crisis Response (MCR), Behavioral Health Crisis Center (BHCC), CBCS providers or the member's Assertive Community Treatment (ACT) Team

Notification and authorization within one (1) business day is required.

Crisis Stabilization for Youths
The goal of CS for youth members is to address behavioral health needs in a way that allows the member to return to the family setting as soon as is reasonably possible. To this effort, regular contact with the member's family is a necessity to communicate the member's ongoing behavioral health needs. Services should include:

1. A preliminary assessment of risk, mental status, and medical stability noting the need for further evaluation or other behavioral health services;
2. Out of home short-term or extended intervention for the member based on initial and ongoing assessment of needs;
3. Follow up with the member and their caretaker and/or family members; and
4. Consultation with a physician or other qualified provider to assist with the member's specific crisis.

Notification and authorization within one (1) business day is required.

Dialectical Behavioral Therapy (DBT)
DBT is a comprehensive, multi-diagnostic, modularized behavioral intervention designed to treat both adults and children/adolescents with severe mental disorders and uncontrolled cognitive, emotional and behavior patterns, including suicidal and/or self-harming behaviors. Includes individual therapy, group therapy, and coaching provided by a team of practitioners. PA is required.

Functional Family Therapy (FFT) and Functional Family Therapy-Child Welfare (FFTCW)
FFT and FFTCW are best practice/family-based approaches to providing treatment to youth who are between the ages of 10 and 18 (0 to 18 for FFT-CW) and are exhibiting significant externalizing behaviors. PA is required.

Homebuilders®
ABHLA offers an intensive, in-home Evidence-Based Program (EBP) utilizing research based strategies for families with children (birth to 18 years) at imminent risk of out of home placement or being reunified from placement. PA is required.

Individual Placement and Support (IPS)
Supported employment services for members with a diagnosed mental illness are covered for members transitioned or diverted from nursing facility level of care through the My Choice Louisiana Program. PA is required.

Intensive Outpatient Treatment (IOP)
IOP includes mental health and substance use treatment and recovery services provided in a community setting. PA is required. Please see the ILO Services of this appendix for more information.

Mental Health Inpatient Hospital Services
Mental health services provided in a hospital setting require notification and authorization within one (1) business day.

Mental Health Rehabilitation Services
Mental health rehabilitation services are covered for children, adolescents, and adults with significant functional impairments resulting from an identified mental health disorder. Services include CPST, PSR, and CI. See individual sections for details.

PA is required.

Rehabilitation Services for Children and Adolescents
The goal of rehabilitation services for children/adolescents is to set the member on their best developmental trajectory. Parents/guardians/caregivers and necessary family members should be considered in treatment plans and involved in care, and involvement must be noted in progress notes.

Rehabilitation Services for Adults
The goal of rehabilitation services for adults is to reduce the disability/aid in recovery to the point that the member is capable of coping with the symptoms of their illness.

Multi-Systemic Therapy (MST)
Policy 7100.33

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.

PA is required along with the following member medical necessity criteria:

- Referral/target ages of 12-17 years;
- Youth exhibits significant externalizing behavior, such as chronic or violent juvenile offenses;
- Child is at risk for out-of-home placement or is transitioning back from an out-of-home setting;
- Externalizing behaviors symptomatology, resulting in a DSM-5 or ICD-10 diagnosis of conduct disorder or other diagnoses consistent with such symptomatology (oppositional defiant disorder, other disruptive, impulse-control, and conduct disorders, etc.);
- Ongoing multiple system involvement due to high-risk behaviors and/or risk of failure in mainstream school settings due to behavioral problems;
- Less intensive treatment has been ineffective or is inappropriate; or
- The youth's treatment planning team or CFT recommends that he/she participate in MST.

For additional criteria, including exceptions, exclusions, and ongoing treatment requirements, please see the above linked policy.

Opioid Treatment Programs (OTPs)
OTPs are medication assisted treatment for members with documented Opioid Use Disorder. Components include:

- An eligibility screening
- A full medical exam to be completed within 14 days of admission
- A comprehensive bio-psychosocial assessment to be completed within the first 7 days of admission to substantiate treatment
- A treatment plan based on the assessments to be developed within 7 days of admission and signed by LMHP or the OTP practitioner.

OTP is covered for members of all ages, but members under the age of 18 require guardian consent when applicable. For full program details, please see the Addiction Services chapter of the LDH Medicaid Services Manual.

Outpatient Therapy by Licensed Practitioners
Outpatient behavioral health services for mental health and substance use treatment are covered. No PA is required with the exception of psychological testing. Licensed practitioners include:

- Provisionally Licensed Professional Counselors
- Provisionally Licensed Marriage and Family Therapists
- Licensed Master Social Workers
- Licensed Mental Health Professionals (LMHP) licensed by the state
    - Psychiatrists
    - Licensed Psychologists

- Medical Psychologists
- Physician's Assistants
- Licensed Professional Counselors
- Licensed Clinical Social Workers
- Licensed Addiction Counselors
- Licensed Marriage and Family Therapists
- Advanced Practice Registered Nurses (Psychiatric Specialists)

Peer Support Services (PSS)
Policy 700.13

Peer Support Services 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 and 21 years of age or older.

In addition to medical necessity criteria outlined in the above linked policy, members must either:

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

PA is required.

Perinatal Depression Screening
ABHLA covers perinatal depression screening administered to a member's caregiver in accordance with the American Academy of Pediatrics/Bright Futures periodicity schedule. The screening can be administered from birth to one (1) year during an Early and Periodic Screening. Providers should only submit a claim for perinatal depression screening under one child regardless of if 2 or more children under the age of 2 present to care on the same day (i.e. twins or siblings both under age 1). When performed on the same day as a developmental screening, provider must append modifier -59 to claims for perinatal depression screening.

Personal Care Services (PCS)
Policy 7000.84

PCS is assistance or supervision for members with a diagnosed mental illness that allows them to complete activities of daily living and live independently. PCS is covered for members transitioned or diverted from nursing facility level of care through the My Choice Louisiana program.

PA is required. Services are generally limited to 20 hour/week. Please see the above linked policy for details.

Psychiatric Residential Treatment Facilities
Covered Psychiatric Residential Treatment Facilities allow members under age 21 to live in a treatment facility to receive necessary behavioral health care. PA is required.

Psychiatric Visits
Visits with a licensed psychiatrist or psychiatric nurse practitioner are covered without PA when the provider is in the ABHLA network.

Psychosocial Rehabilitation (PSR)
PSR services are designed to help individuals cope with or eliminate functional deficits or barriers of a diagnosed mental illness. Components of PSR include skill building, restoring/rehabilitating social and interpersonal skills, and restoring/rehabilitating daily living skills. PA is required.

Substance Use Disorder (SUD) Inpatient and Residential Services
Inpatient and residential SUD services are for members who require ongoing support and treatment outside of the home, either in a community residential facility or an inpatient hospital setting. PA is required.

Substance Use Disorder Intensive Outpatient Services (SUD IOP)

For Substance Use Disorder Intensive Outpatient Treatment, HCPC code H0015 may not be billed for more than one unit per day. Please note the following parameters for the appropriate provision and billing of SUD IOP per the **LDH Behavioral Health Services Provider Manual (Chapter 2 of the Medicaid Services Manual**):

- Adult IOP group must consist of a minimum of 3 hours per day, for a minimum of 3 days per calendar week (9 contact hours) and a maximum of 5 days per calendar week.
- Youth IOP group must consist of a minimum of 3 hours per day, for a minimum of 2 days per calendar week (6 contact hours) and a maximum of 5 days per calendar week.
- For both youth and adults receiving SUD IOP, a minimum of 1 session of individual therapy must be provided within each 30-day service period, with a maximum of 4 sessions per 30-day service period.
- The maximum number of SUD IOP treatment hours for adolescents and adults is 19 hours per week.

Telehealth Services

Substance Use Disorder Services

LMHP's providing assessments, evaluations, individual psychotherapy, family psychotherapy, and medication management services within intensive outpatient or outpatient treatment may be reimbursed when conducted via telecommunication technology. The LMHP is responsible for acting within the telehealth scope of practice as decided by the respective licensing board. The provider must bill the procedure code (CPT codes) with modifier "95", as well as the correct place of service, either POS 02 (other than home) or 10 (home). Reimbursement will be at the same rate as a face-to-face service. Exclusions: Methadone admission visits conducted by the admitting physician within Opioid Treatment Programs are not allowed via telecommunication technology.

Opioid Treatment

LMHP's providing assessments, evaluations, individual psychotherapy, family psychotherapy, and medication management services offered within Opioid Treatment Programs may be reimbursed when conducted via telecommunication technology. The LMHP is responsible for acting within the telehealth scope of practice as decided by the respective licensing board. The provider must bill the procedure code (CPT codes) with modifier "95", as well as the correct place of service, either POS 02 (other than home) or 10 (home). Reimbursement will be at the same rate as a face-to-face service. Exclusions: Methadone admission visits conducted by the admitting physician within Opioid Treatment Programs are not allowed via telecommunication technology.

Applied Behavior Analysis

ABHLA will reimburse the use of telehealth, when appropriate, for rendering certain ABA services for the care of new or established patients or to support the caregivers of new or established patients.

Telehealth requires prior authorization for services. Subsequent assessments and behavior treatment plans can be performed remotely via telehealth only if the same standard of care can be met. Previously approved prior authorizations can be amended to increase units of care and/or to reflect re-assessment goals.

The following codes can be performed via telehealth; however, requirements for reimbursement are otherwise unchanged from in-person ABA. Relevant CPT codes include: 97151, 97155, 97152, 97156, 97153, 97157, 97154, 97158. ABA services rendered via telehealth must have the appropriate place of service indicated (02-other than home or 10-home) based on the member's location at the time of service. CPT codes must also be appended with modifier -95.

Telehealth services must be based on ABA methodology and rendered or directed by a registered line technician (RLT), licensed behavior analyst (LBA), or certified assistant behavior analyst (CaBA). The caregivers/patients and RLT/LBA/CaBA must be linked through an interactive audio/visual telecommunications system. The purpose of this service is to provide family adaptive behavior treatment guidance, which helps parents and/or caregivers properly use treatment procedures designed to teach new skills and reduce challenging behaviors.

Telehealth supervision of in-home therapy rendered by a RLT must utilize an LBA/CaBA to provide remote supervision. Each RLT must obtain ongoing supervision as approved in the patient's plan of care. Supervision may be conducted via telehealth in lieu of the LBA/CaBA being physically present. The purpose of supervision is to improve and maintain the

behavior analytic, professional, and ethical repertoires of the RLT and facilitate and maintain the delivery of high-quality services to his or her patients.

The licensed supervising professional should supervise no more than 24 technicians a day. More technicians may be supervised if a CaBA is part of the professional support team or depending on the mix of needs in the supervisor's caseload. The licensed professional can supervise no more than 10 CaBAs.

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; and
- Custodial care that:
    - Is provided primarily to assist in the activities of daily living (ADLs), such as bathing, dressing, eating, and maintaining personal hygiene and safety;
    - Is provided primarily for maintaining the safety of the beneficiary or anyone else; or
    - Could be provided by persons without professional skills or training.

Therapeutic Group Homes

These services allow youth to live in a home-like setting with a small group of other youth in order to receive needed care. Therapeutic group homes are covered for members under age 21. PA is required.

Transcranial Magnetic Stimulation (TMS)

Policy 7200.78

Effective 8/2/2024, TMS is covered when medically necessary for treatment of major depression only. TMS can be performed in an office setting and is considered medically necessary when all of the following criteria are met:

1. Member is 18 years of age or older; AND
2. Diagnosis of major depressive disorder (DSM 5 diagnostic terminology); AND
3. Failure or intolerance to psychopharmacologic agents, choose ONE of the following:
    a. Failure of psychopharmacologic agents, BOTH of the following:
        i. Lack of clinically significant response in the current depressive episode to four trials of agents from at least two different agent classes; AND
        ii. At least two of the treatment trials were administered as an adequate course of mono- or poly-drug therapy with antidepressants, involving standard therapeutic doses of at least six weeks duration.
    b. The member is unable to take anti-depressants due to ONE of the following:
        i. Drug interactions with medically necessary medications; OR
        ii. Inability to tolerate psychopharmacologic agents, as evidenced by trials of four such agents with distinct side effects in the current episode; AND
4. No contraindications to TMS are present (see section on contraindications); AND
5. Electroconvulsive therapy has previously been attempted, is medically contraindicated, or has been offered and declined by the member.

Retreatment is considered medically necessary when all of the following criteria have been met:

1. Current major depressive symptoms have worsened by 50 percent from the prior best response of the PHQ-9 score; AND
2. Prior treatment response demonstrated a 50 percent or greater reduction from baseline depression scores; AND

3. No contraindications to TMS are present (see section on contraindications).

A referral from a psychiatrist is required and must be submitted prior to treatment. Please see the above linked policy for details.