Behavioral Health Crisis Care

Clinical Policy ID: CCP.1513-04

Recent review date: 6/2024

Next review date: 10/2025

Policy contains: Behavioral health, crisis care, crisis stabilization, mental health, mobile crisis.

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, on a case-by-case basis by AmeriHealth Caritas Louisiana 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.

Coverage policy

Behavioral health crisis care services, as defined by the Louisiana Department of Health, are clinically proven and, therefore, medically necessary for mental health crises. Crisis intervention and crisis intervention follow up services are available to children and adults through Mental Health Rehabilitation agencies. The Louisiana Crisis Response System offers four different BH crisis services to adults 21 years of age and older. These services are provided by selected Behavioral Health providers specifically trained to provide behavioral health crisis care (Substance Abuse and Mental Health Services Administration, 2014, 2020).

Note: Behavioral health crisis services include the following:

Crisis Intervention

Crisis intervention and crisis intervention follow-up are provided by mental health rehabilitation services. The crisis intervention is reimbursed on a per diem fee and crisis intervention follow-up is reimbursed by a fee for every 15 minutes.
Louisiana Crisis System of CareMobile Crisis Response, reimbursed by a per diem fee

- Community Brief Crisis Support, reimbursed by a every 15-minute fee
- Behavior Health Crisis Center, reimbursed by a per diem fee or hourly rate up to 3 hours
- Crisis Stabilization, reimbursed by a per diem fee.

Limitations

No limitations were identified during the writing of this policy.

Alternative covered services

Standard behavioral health treatments for adults.

Background

The Louisiana Department of Health offers the Louisiana Crisis Response System for adult Medicaid beneficiaries who are experiencing a mental health crisis. The program consists of an initial or emergent psychiatric crisis response through the MCO crisis call line or 988 , which is intended to provide relief, resolution or intervention through crisis supports and services that include Mobile Crisis Response, Community Brief Crisis Supports, Behavioral Health Crisis Centers, and/or Crisis Stabilization.

Mobile Crisis Response (MCR): a mobile service that is available as an initial intervention for individuals in a self-identified crisis, in which teams deploy to where the individual is located in the community. The service is available twenty-four (24) hours a day, seven (7) days a week and includes maximum one (1) hour urban and two (2) hour rural face-to-face/onsite response times

Community Brief Crisis Support (CBCS): a face to face intervention available to individuals subsequent to receipt of MCR, BHCC, or CS. This ongoing crisis intervention response is intended to be rendered for up to fifteen (15) days and are designed to provide relief, resolution and intervention through maintaining the member at home/community, de-escalating behavioral health needs, referring for treatment needs, and coordinating with local providers

Behavioral Health Crisis Care (BHCC): a facility based service that operates twenty-four (24) hours a day, seven (7) days a week as a walk-in center providing short-term behavioral health crisis intervention, offering a community based voluntary home-like alternative to more restrictive settings. LOS: 23 hours or less

Crisis Stabilization (CS): a short-term bed-based crisis treatment and support services for members who have received a lower level of crisis services and are at risk of hospitalization or institutionalization, including nursing home placement. LOS: 3-5 days

Services are not to be utilized as step-down services from residential or inpatient psychiatric or substance use disorder treatment service settings and are not intended to substitute for already-approved and accessible community psychiatric support and treatment, psychosocial rehabilitation, or assertive community treatment services with a member's already-established provider (Louisiana Department of Health, 2022).

Findings

In June 2014, the Substance Abuse and Mental Health Services Administration issued a report on the effectiveness of crisis services. The document included 69 references, 40 of which were peer-reviewed, along with interviews with representatives of eight states, discussing approaches to crisis care in behavioral health (Substance Abuse and Mental Health Services Administration, 2014).

In February 2020, the Administration followed with national guidelines aimed at providers and insurers of mental health services. The guidelines are a toolkit, or a “how-to” document on best practices in community-based mobile crisis intervention best practices. While the document focused on structure and process, it suggested ways to measure outcomes, including two case studies of effectiveness and cost effectiveness, along with seven interviews with professionals engaged in crisis care (Substance Abuse and Mental Health Services Administration, 2020).

In December 2021, the Centers for Medicare and Medicaid Services issued a letter to state health officials. The purpose of the letter was to give guidance on the scope of/payments for qualifying community-based mobile crisis intervention services authorized by Section 9813 of the American Rescue Plan Act of 2021 (Centers for Medicare & Medicaid Services, 2021).

The letter defined the three components of a crisis system, namely:

- A call center staffed 24 hours a day, seven days a week
- Mobile response teams (other than law enforcement)
- Crisis receiving/stabilization facilities (instead of emergency departments or hospitals)

It also identified best practices in crisis care, including:

- The incorporation of training programs for staff
- Responses to crises performed without law enforcement
- Inclusion of real-time Global Positioning System technology
- Scheduling of outpatient follow-up and services

The peer-reviewed literature addressing effectiveness of crisis care has failed to show efficacy due to limited evidence and/or limitations in methods used. Examples of large-scale studies include:

- Limited evidence and inconsistent outcome measures in crisis-focused interventions (Anderson, 2020).
- Interventions for self-injurious thoughts/behaviors were small and have not improved (Fox, 2020).
- Interventions other than usual care did not reduce hospital use for dementia (Godard-Sebilllotte, 2019).
- Evidence for crisis lines for suicide preventions, versus other modalities, is lacking (Hoffberg, 2020).
- Empirical data on efficacy of suicide prevention helplines and crisis centers is scarce (Mishare, 2022).
- There is limited evidence on efficacy of crisis teams for elderly persons with dementia (Streater, 2017).
- Evidence on efficacy of crisis resolution home treatment for the elderly is lacking (Toot, 2011).
- Conclusions cannot be drawn from available evidence on crisis resolution teams (Wheeler, 2015).

However, some large-scale studies have shown improvements in outcomes for behavioral health crisis care:

- A review of 19 studies showed improved psychological outcomes resulted from in-home interventions: while a large number of patients were admitted, stays were shorter after interventions (Clisu, 2022).
- A study of 6,493 children who used mobile crisis services reduced subsequent emergency visits by 25% (Fendrich, 2019).
- A Cochrane review of eight studies (n = 1,144) of persons with schizophrenia showed crisis intervention versus standard care may reduce repeat hospital admissions, reduce family burden, improve mental state, and improve satisfaction (Murphy, 2015).
- A review of 19 studies found increased satisfaction with alternative models, and identified various interventions that may be effective during a crisis (Vusio, 2020).

- Nine studies of moderate quality suggest community-based alternatives may be cheaper and produce greater satisfaction than acute wards for the mentally ill (Lloyd-Evans, 2009).

References

On May 11, 2024, we searched PubMed and the databases of the Cochrane Library, the U.K. National Health Services Centre for Reviews and Dissemination, the Agency for Healthcare Research and Quality, and the Centers for Medicare & Medicaid Services. Search terms were Behavioral health, crisis care, crisis stabilization, mental health, mobile crisis. We included the best available evidence according to established evidence hierarchies (typically systematic reviews, meta-analyses, and full economic analyses, where available) and professional guidelines based on such evidence and clinical expertise.

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Policy updates

5/2022: initial review date and clinical policy effective date: 5/2022

1/2023: Policy updated to reflect each component of mental health rehabilitation in the coverage section; language from Louisiana Department of Health manual included as appendices 1-5.

6/2023: Policy references updated.
6/2024: Policy references updated. No policy changes warranted.

Appendix 1

Behavioral Health Crisis Care (Effective 4/1/2022)

Behavioral Health Crisis Care (BHCC) services are an initial or emergent psychiatric crisis response intended to provide relief, resolution and intervention through crisis supports and services during the first phase of a crisis for adults. BHCC Centers (BHCCC) operate twenty-four (24) hours a day, seven (7) days a week as a walk-in center providing short-term mental health crisis response, offering a community based voluntary home-like alternative to more restrictive settings, such as the emergency departments, or coercive approaches, such as Physician Emergency Certificates (PECs), law enforcement holds, or Orders of Protective Custody (OPC). BHCCC are designed to offer recovery oriented and time limited services up to twenty-three (23) hours per intervention, generally addressing a single episode that enables a member to return home with community-based services for support or be transitioned to a higher level of care as appropriate if the crisis is unable to be resolved.

Components

1. Provide services (screening, assessment, interventions, and care coordination) as outlined in the general section;

2. A registered nurse or licensed practical nurse practicing within the scope of his or her license performs a medical screen to evaluate for medical stability; and

3. Providing follow up to the member and authorized member's caretaker and/or family within twenty-four (24) hours as appropriate and desired by the member and up to seventy-two (72) hours to ensure continued stability post crisis for those not accessing higher levels of care or another crisis service, including but not limited to:

a. Telephonic follow-up based on clinical individualized need; and

b. Additional calls/visits to the member following the crisis as indicated in order to stabilize the crisis. If the member indicates no further communication is desired, it must be documented in the member's record.

Eligibility Criteria

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

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

Service Utilization

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

Allowed Mode(s) of Delivery

1. Individual; and

2. On-site.

Allowed Places of Service

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

Staffing Requirements

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

1. Medical Director or designated prescriber (physician/psychiatrist, APRN, Medical Psychologist) must be available twenty-four (24) hours a day /seven (7) days a week for consultation and medication management;

2. LMHPs on duty to adequately to meet the member's needs;

3. Registered nurse or licensed practical nurse on duty to adequately to meet the member's needs;

4. RPSS on duty to adequately to meet the member's needs;

5. At least two (2) staff must be present at all times. Clerical staff do not qualify for this requirement; and

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

Allowed Provider Types and Specialties

1. PT AG Behavioral Health Rehabilitation Provider Agency PS 8E CSoC/ Behavioral Health;

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

3. PT 77 Mental Health Rehab PS 78 MHR; and

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

Exclusions

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

Appendix 2

Community Brief Crisis Support (CBCS) (Effective 3/1/2022)

Community Brief Crisis Support (CBCS) services are an ongoing crisis response intended to be rendered for up to fifteen (15) days and are designed to provide relief, resolution and intervention through maintaining the member at home/community, de-escalating behavioral health needs, referring for treatment needs, and coordinating with local providers. CBCS is a face-to-face, time-limited service provided to a member who is experiencing a psychiatric crisis until the crisis is resolved and the member can return to existing services or be linked to alternative behavioral health services.

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

Components

1. Provide services (screening, assessment, interventions, and care coordination) as outlined in the general section; and

2. Providing follow up to the member and authorized member's caretaker and/or family within twenty-four (24) hours as appropriate and desired by the member and up to fifteen (15) days following initial contact with the CBCS provider once the previous CI (MCR, BHCC) provider has discharged the member to ensure continued stability post crisis for those not accessing higher levels of care, including but not limited to:

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

    b. Additional calls/visits to the member following the crisis as indicated in order to stabilize the crisis. If the member indicates no further communication is desired, it must be documented in the member's record.

Eligibility Criteria

The medical necessity for these rehabilitative services must be determined by and services recommended by an LMHP or physician to promote the maximum reduction of symptoms and/or restoration of a member aged twenty-one (21) years and over to his/her best age-appropriate functional level. This service will be rendered to eligible members after a referral is made from MCR or BHCC. Members in crisis who require this service may be using substances during the crisis, and this substance use will not, in and of itself, disqualify them for eligibility for the service.

All members who self-identify as experiencing a seriously acute psychological/emotional change, that results in a marked increase in personal distress and that exceeds the abilities and the resources of those involved to

effectively resolve it, are eligible for ongoing crisis services as long as medical necessity is met and the members is not already linked to an existing MHR or ACT provider.

Service Utilization

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

Allowed Mode(s) of Delivery

1. Individual;

2. On-site (at the CBCS office); or

3. Off-site.

Allowed Places of Service

This is primarily a community-based service delivered in member's natural setting with exceptions for office-based settings when desired or requested by the member or through some other exception as documented in the member record. When preferred, office-based services are permitted but should not be the primary mode of service delivery.

Staffing Requirements

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

1. Medical Director or designated prescriber (physician/psychiatrist, APRN, Medical Psychologist) must be available twenty-four (24) hours a day, /seven (7) days a week for consultation and medication management;

2. LMHPs on duty to adequately meet the member's needs; and

3. RPSS on duty to adequately meet the member's needs.

Allowed Provider Types and Specialties

1. PT AG Behavioral Health Rehabilitation Provider Agency PS 8E CSoC/ Behavioral Health;

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

3. PT 77 Mental Health Rehab PS 78 MHR; and

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

Exclusions

1. CBCS services cannot be rendered in emergency departments (EDs);

2. CBCS services cannot be rendered in substance use residential facilities or inpatient facilities;

3. CBCS services cannot be approved for incarcerated individuals;

4. CBCS services are not to be utilized as step down services from other residential or inpatient psychiatric service settings; and

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

Billing

1. Only direct staff face-to-face time with the member may be billed. CBCS is a face-to-face intervention with the member present; family or other collaterals may also be involved;

2. Time spent in travel, documenting, supervision, training, etc. has been factored into the indirect unit cost and may not be billed directly; and

3. CBCS and established behavioral health services may be billed on the same day one (1) time to allow for the hand off.

Appendix 3

Crisis Stabilization for Adults

Crisis Stabilization (CS) for adults is a short-term bed-based crisis treatment and support service for members who have received a lower level of crisis services and are at risk of hospitalization or institutionalization, including nursing home placement. CS is utilized when additional crisis supports are necessary to stabilize the crisis and ensure community tenure in instances in which more intensive inpatient psychiatric care is not warranted or when the member's needs are better met at this level. This service is designed to ameliorate a psychiatric crisis and/or reduce acute symptoms of mental illness and to provide crisis relief, resolution, and intensive supportive resources for adults who need temporary twenty-four (24) hours a day, seven (7) days a week support and is not intended to be a housing placement.

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

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

Components

Assessment

1. The psychiatric diagnostic evaluation of risk, mental status and medical stability must be conducted by a licensed mental health professional (LMHP) or psychiatrist with experience regarding this specialized mental health service and practicing within the scope of his or her professional license. This assessment should build upon what is learned by previous crisis response providers or the Assertive Community Treatment (ACT) provider and should include contact with the member, family members or other collateral sources (e.g., caregiver, school personnel) with pertinent information for the purpose of the evaluation and/or referral to and coordination with other alternative behavioral health services at an appropriate level. If the member expressly refuses to include family or other collaterals sources, it must be documented in the member record. If a psychiatric diagnostic evaluation was completed within thirty (30) days, another evaluation does not need to be completed at this time, but an update to capture the member's current status must be added to the previous evaluation; and

2. A registered nurse or licensed practical nurse practicing within the scope of his or her license performs a medical screen to evaluate for medical stability.

Interventions

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

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

2. The service will include brief interventions using person centered approaches, such as, crisis resolution, self-help skills, peer support services, social skills, medication support, and co-occurring substance use disorder treatment services through individual and group interventions. The service must be provided under the supervision of an LMHP or psychiatrist with experience regarding this specialized behavioral health service;

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

4. Support, education, and consultation is provided to the member, family, and collateral supports.

Care Coordination

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

a. Coordinating the transfer to alternate levels of care within 24 hours when warranted, including but not limited to:

i. Primary medical care - when the member requires primary medical care with an existing provider;

ii. Community based behavioral health provider - when the member requires ongoing support at a lower level of care with the member's existing behavioral health provider. The member should return to existing services as soon as indicated and accessible;

iii. Community Brief Crisis Support (CBCS) - when the member requires ongoing support at home or in the community, if the member does not have an existing behavioral health provider who can meet their current critical needs as defined in the discharge plans;

iv. Crisis Stabilization (CS) – when the member may need additional time outside of the home without being at immediate risk for inpatient treatment due to experiencing severe intoxication or withdrawal episodes that cannot be managed safely in this setting, at immediate suicide risk, or currently violent;

v. Inpatient treatment – when the member is in medical crisis, experiencing severe intoxication or withdrawal episodes, or is actively suicidal, homicidal, gravely disabled, or currently violent; and

vi. Residential substance use treatment - when the member requires ongoing support outside of the home for a substance use disorder.

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

b. Coordinating contact through a warm handoff with the member's Managed Care Organization (MCO) to link the member with no current behavioral health provider and/or primary medical care provider to outpatient services as indicated;

c. Coordinating contact through a warm handoff with the member's existing or new behavioral health provider; and

d. Providing any member records to the existing or new behavioral health provider or to another crisis service to assist with continuing care upon referral.

Follow-Up

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

a. Telephonic follow-up based on clinical individualized need; and

b. Additional calls/visits to the member following the crisis unless the member indicates no further communication is desired as documented in the member's record.

Eligibility Criteria

The medical necessity for these rehabilitative services must be determined by and recommended by an LMHP or physician to promote the maximum reduction of symptoms and/or restoration of an individual to his/her best age-appropriate functional level. Referrals to CS must be completed by the Mobile Crisis Response (MCR), Behavioral Health Crisis Care (BHCC), Community Brief Crisis Support (CBCS) providers or ACT teams.

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

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

Service Utilization

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

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

Service Delivery

All mental health services must be medically necessary in accordance with the Louisiana Administrative Code LAC 50:I.1101. The medical necessity for services shall be determined by an LMHP or physician who is acting within the scope of his or her professional license and applicable state law. There shall be member involvement throughout the planning and delivery of services. Services shall be:

1. Delivered in a culturally and linguistically competent manner;

2. Respectful of the individual receiving services;

3. Appropriate to individuals of diverse racial, ethnic, religious, sexual or gender identities and other cultural and linguistic groups; and

4. Appropriate for age, development; and education.

Allowed Modes of Delivery

1.On-site

Provider Responsibilities

1. All services shall be delivered in accordance with federal and state laws and regulations, the applicable Louisiana Medicaid Provider manual and other notices or directives issued by the Department. The provider shall create and maintain documents to substantiate that all requirements are met. (See Section 2.6 of this manual chapter regarding record keeping);

2. Any licensed practitioner providing behavioral health services must operate within the scope of practice of his or her license; and

3. The provider shall maintain treatment records that include the name of the individual, a treatment plan, the dates of services provided, the nature and content of the services provided, and progress made toward functional improvement and goals in the treatment plan.

Supervision of Non-Licensed Staff

Crisis Stabilization providers must employee at least one LMHP or psychiatrist to specifically serve as a clinical supervisor to assist in the design and evaluation of crisis planning and crisis stabilization services. LMHPs serving in the role of clinical supervisor are restricted to medical psychologist, licensed psychologist, licensed clinical social worker (LCSW), licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), or licensed Advanced Practice Registered Nurse (APRN) with a psychiatric specialization. The supervisor must be available for supervision responsibilities twenty-four (24) hours a day and seven (7) days a week to respond to supervision needs of non-licensed staff responding to crises.

Services provided by non-licensed staff must be provided under regularly scheduled supervision listed below and if applicable in accordance with requirements established by the practitioner's professional licensing board under which he or she is pursuing a license.

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

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

2. Staff shall receive a minimum of four (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, which shall consist of no less than one (1) hour of individual supervision. Each month, the remaining hours of supervision may be in a group setting. Given consideration of case load and acuity, additional supervision may be indicated;

3. The LMHP (excluding LACs) or the psychiatrist supervisor must ensure services are in compliance with the established requirements of this service;

4. Group supervision means one LMHP (excluding LACs) or psychiatrist supervisor and not more than six (6) supervisees in supervision session;

5. A maximum of 75% of the individual and group supervision may be telephonic or via a secure Health Insurance Portability and Accountability Act (HIPAA) compliant online synchronous videoconferencing platform. Texts and/or emails cannot be used as a form of supervision to satisfy this requirement; and

6. Supervision with the LMHP or psychiatrist must:

a. Have intervention notes that are discussed in supervision must have the LMHP or psychiatrist supervisor's signature; and

b. Have documentation reflecting the content of the training and/or clinical guidance. The documentation must include the following:

i. Date and duration of supervision;

ii. Identification of supervision type as individual or group supervision;

iii. Name and licensure credentials of the LMHP or psychiatrist supervisor;

iv. Name and credentials (provisionally licensed, master's degree, bachelor's degree, or high school degree) of the supervisees;

v. The focus of the session and subsequent actions that the supervisee must take;

vi. Date and signature of the LMHP or psychiatrist supervisor;

vii. Date and signature of the supervisees; and

viii. Start and end time of each supervision session.

Reporting Requirements

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

Provider Qualifications

Facility

To provide crisis stabilization services, facilities must:

1. Be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or The Joint Commission (TJC).

Denial, loss of, or any negative change in accreditation status must be reported in writing immediately upon notification to the managed care entities with which the facility contracts or is being reimbursed; NOTE: Facilities must apply for accreditation and pay accreditation fees prior to being contracted and reimbursed by a Medicaid managed care entity, and must maintain proof of the accreditation application and associated fee payment. Facilities must attain full accreditation within twelve (12) months of the initial accreditation application date.

2. Have a minimum capacity of four (4) beds and a maximum capacity of sixteen (16) beds;

3. Arrange for and maintain documentation that all persons prior to employment (or contracting, volunteering, or as required by law), have passed criminal background checks , including sexual offender registry checks, by an agency authorized by the Office of State Police to conduct criminal background checks in accordance with the Crisis Receiving Center Level III licensing regulations established by LAC 48:I.Chapter 53: a. Criminal background checks must be performed as required by La. R.S. 40:1203.1 et seq., in accordance with La. R.S. 15:587 et seq, and any other applicable state or federal law. Criminal background checks performed over ninety (90) days prior to date of employment will not be accepted as meeting this requirement.

4. Not hire individuals failing to meet criminal background check requirements and regulations. Individuals not in compliance with criminal background check requirements and regulations shall not be utilized on an employment, contract or volunteer basis;

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

6. Review the Department of Health and Human Services' Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) and the LDH State Adverse Actions website prior to hiring or contracting with any employee or contractor who performs services that are compensated with Medicaid/Medicare funds, including but not limited to licensed and non-licensed staff, interns and contractors:

a. Once employed, the lists must be checked once a month thereafter to determine if there is a finding that an employee or contractor has abused, neglected or extorted any individual or if employee or contactor has been excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General; and

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

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

8. Arrange for and maintain documentation that all persons, prior to employment, are free from Tuberculosis (TB) in a communicable state as defined by the LAC 51:II.Chapter 5 to reduce the risk of such infections in recipients and staff. Results from testing performed over thirty (30) days prior to the date of employment will not be accepted as meeting this requirement;

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

10. Maintain documentation that all direct care staff, who are required to complete First Aid, cardiopulmonary resuscitation (CPR) and seizure assessment training, complete American Heart Association (AHA) recognized training within ninety (90) days of hire, which shall be renewed within a time period recommended by the AHA. Psychiatrists, APRNs/PAs, RNs and LPNs are exempt from this training. (See Appendix D);

11. Maintain a personnel file for each employee, contractor, and individual with whom the facility has an agreement to provide direct care services or to fulfill core and other staffing requirements. Documentation of employment, contracting or agreement must be in writing and executed via written signatures;

12. Maintain documentation for verification of completion of required trainings for all staff; and

13. Ensure and maintain documentation that all persons employed by the organization complete training in the OBH approved Crisis Response curriculum. (See Appendix D).

Staff

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

1. Must be at least twenty-four (24) years of age;

2. Unlicensed staff must have a minimum of bachelor's degree (preferred) OR an associate's degree and two (2) years of work experience in the human services field OR meet Recognized Peer Support Specialist (RPSS) qualifications. (See the Peer Support Services chapter of the manual);

3. Satisfactory completion of criminal background checks pursuant to the applicable provider license type issued by Health Standards, La R.S. 40:1203.1 et seq., and any applicable state or federal law or regulation;

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

5. Direct care staff must not have a finding on the Louisiana State Adverse Action List:

a. Pass a Tuberculosis (TB) test prior to employment in accordance with the LAC 51:II.Chapter 5; OR be free from Tuberculosis (TB) in a communicable state as defined by the LAC 51:II.Chapter 5.

6. Pass drug screening tests as required by the facility's policies and procedures;

7. Complete American Heart Association (AHA) recognized First Aid, CPR and seizure assessment training. Psychiatrists, APRNs/PAs, RNs and LPNs are exempt from this training. (See Appendix D);

8. Comply with Direct Service Worker Registry law established by La. R.S. 40:2179 et seq. and meet any additional qualifications established under Rule promulgated by LDH in association with this statute;

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

10. Complete training curriculum approved by OBH prior to providing the service. (See Appendix D).

The RPSS must successfully complete a comprehensive peer training plan and curriculum that is inclusive of the Core Competencies for Peer Workers, as outlined by the Substance Abuse and Mental Health Services Administration (SAMHSA), and has been approved by the Office of Behavioral Health (OBH). (See the Peer Support Services chapter of the Louisiana Medicaid Behavioral Health Services Provider manual).

Staffing Requirements

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

1. RPSS on duty adequate to meet the member's needs;

2. Staffing must be sufficient that there are at least two (2) staff present at all time; and

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

Allowed Provider Types and Specialties

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

Limitations/Exclusions

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

1. Services rendered in an institute for mental disease; and

2. The cost of room and board.

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

Appendix 4

Mobile Crisis Response (Effective 3/1/2022)

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

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

Components

1. Provide services (screening, assessment, interventions, and care coordination) as outlined in the general section; and

2. Provide follow up to the member and authorized member's caretaker and/or family within twenty-four (24) hours as appropriate and desired by the member and up to seventy-two (72) hours to ensure continued stability post crisis for those not accessing higher levels of care or another crisis service, including but not limited to:

    a. Telephonic or face to face follow-up based on a clinical individualized need; and
    b. Additional calls/visits to the member following the initial crisis response as indicated in order to stabilize the individual in the aftermath of the crisis. If the member indicates no further communication is desired, it must be documented in the member's record.

Eligibility Criteria

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

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

Service Utilization

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

NOTE: Such initial encounters will be subject to retrospective review. In this way, IF it is determined that the response time is beyond one (1) – two (2) hours (e.g., next day or later), and/or if available/reviewed documentation does NOT support the crisis, the payment might be subject to recoupment.

Allowed Mode(s) of Delivery

1. Individual;

2. On-site (the MCR office); or

3. Off-site.

Allowed Places of Service

This is primarily a community-based service delivered in member's natural setting with exceptions for office-based when desired or requested by the member. Any exceptions to providing the service in the member's natural setting must include a justification documented in the member record. When preferred, office-based services are permitted but should not be the primary mode of service delivery.

Staffing Requirements

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

1. Medical Director or designated prescriber (physician/psychiatrist, APRN, Medical Psychologist) must be available twenty-four (24) hours a day /seven (7) days a week for consultation and medication management;

2. LMHPs on duty to adequately meet the member's needs; and

3. RPSS on duty to adequately meet the member's needs.

Response Team Staffing Requirements

1. Unlicensed staff and RPSS deploy in teams initially to assess and address the crisis, only enlisting the assistance of an LMHP if needed. Exceptions to the team deployment may be made by the team leader; and

2. One staff person may deploy after the initial assessment, if appropriate as determined by the team leader.

Allowed Provider Types and Specialties

1. PT AG Behavioral Health Rehabilitation Provider Agency PS 8E CSoC/ Behavioral Health;

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

3. PT 77 Mental Health Rehab PS 78 MHR; and

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

Exclusions

1. The initial MCR contact cannot be rendered in emergency departments (EDs). The MCR provider is allowed to continue a 72-hour encounter if it was initiated prior to the ED visit;

2. MCR services cannot be rendered in substance use residential facilities or inpatient facilities;

3. MCR services cannot be approved for incarcerated individuals; and

4. MCR services are not to be utilized as step down services from residential or inpatient psychiatric service settings, or Substance Use Disorder (SUD) residential service settings.

Billing

1. Only direct staff face-to-face time with the member or family members may be billed for the initial response. MCR is a face-to-face intervention with the member present. Family or other collaterals may also be involved;

2. The initial MCR dispatch per diem covers the first twenty-four (24) hours. Any follow up provided within the first 24 hours is included in the per diem. MCR follow-up services can only be billed for any additional follow up beyond 24 hours and up to 72 hours after dispatch;

3. Collateral contacts should involve contacts with family members or other individuals having a primary relationship with the member receiving treatment and must be for the benefit of the member. These contacts are encouraged, included within the rate, and are not billed separately; and

4. Time spent in travel, documenting, supervision, training, etc. has been factored into the indirect unit cost and may not be billed directly.

Appendix 5

Crisis Intervention

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

Components

The components of Crisis Intervention services are as follows:

1. A preliminary assessment of risk, mental status and medical stability and the need for further evaluation or other mental health services must be conducted. This includes contact with the member, family members or other collateral sources (e.g., caregiver, school personnel) with pertinent information for the purpose of a preliminary assessment and/or referral to other alternative mental health services at an appropriate level;

2. Short-term CIs, including crisis resolution and debriefing with the identified Medicaid-eligible individual;

3. Follow up with the individual and, as necessary, with the individuals' caretaker and/or family members; and

4. Consultation with a physician or with other qualified providers to assist with the individuals' specific crisis.

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

CI Provider Qualifications Agency

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

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

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

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

3. Services must be provided under the supervision of a licensed mental health professional (LMHP) or physician who is acting within the scope of his/her professional license and applicable state law. The term "supervision" refers to clinical support, guidance and consultation afforded to non-licensed staff, and should not be confused with clinical supervision of bachelor's or master's level individuals or provisionally licensed individuals pursuing licensure. Such individuals shall comply with current, applicable scope of practice and supervisory requirements identified by their respective licensing boards;

4. Arranges for and maintains documentation that prior to employment (or contracting, volunteering, or as required by law) individuals pass criminal background checks, including sexual offender registry checks, in accordance with all of the law and regulations below:

    a) The Behavioral Health Service Provider (BHSP) licensing regulations established by the Louisiana Administrative Code (LAC) 48:I.Chapter 56, which includes those for owners, managers, and administrators; any individual treating children and/or adolescents; and any non-licensed direct care staff;

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

    c) La. R.S. 15:587, as applicable; and

    d) Any other applicable state or federal law.

5. Providers shall not hire individuals failing to meet criminal background check requirements and regulations. Individuals not in compliance with criminal background check requirements and regulations shall not be utilized on an employment, contract nor volunteer basis. Criminal background checks performed over ninety (90) days prior to the date of employment will not be accepted as meeting the criminal background check requirement. Results of criminal background checks are to be maintained in the individual's personnel record;

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

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

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

7. Arranges for and maintains documentation that all persons, prior to employment, are free from Tuberculosis (TB) in a communicable state via skin testing (or chest exam if recommended by physician) to reduce the risk of such infections in members and staff. Results from testing performed over thirty (30) days prior to date of employment will not be accepted as meeting this requirement;

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

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

10. Maintains documentation of verification of completion of required trainings for all staff; and

11. Ensures and maintains documentation that all non-licensed persons employed by the organization complete training in a recognized Crisis Intervention curriculum prior to handling or managing crisis calls, which shall be updated annually.

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

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

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

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

continue to be reimbursed by Medicaid until April 1, 2018, provided that the provider complies with all other Medicaid requirements.

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

Notwithstanding the above paragraph, the following also applies:

1. A licensed Home and Community-Based Service Provider may not perform CI services unless it also has a BHSP license issued by LDH Health Standards; and

2. A school based health clinic/center or community mental health center may not perform CI services unless it also has a BHSP license issued by LDH Health Standards.

Federally Qualified Health Centers

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

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

Staff
Staff must operate under an agency license issued by LDH Health Standards. Crisis intervention services may not be performed by an individual who is not under the authority of an agency license. Staff must also meet the following requirements:

To provide crisis intervention, staff must be at least twenty (20) years old and have an associate's degree in social work, counseling, psychology or a related human services field or two years of equivalent education and/or experience working in the human services field. The Human Service Field is defined as an academic program with a curriculum content in which at least 70 percent of the required courses are in the study of behavioral health or human behavior. Additionally, the staff must be at least three (3) years older than an individual under the age of eighteen (18).

NOTE – HUMAN SERVICES FIELD: It is LDH's position that degrees in Criminal Justice, Education, and Public Administration (among others) do not generally meet the requirements necessary to be considered human services related fields for purposes of providing Crisis Intervention services. Provider agencies employing

individuals with degrees in academic majors other than counseling, social work, psychology or sociology for the provision of Crisis Intervention services must maintain documented evidence in the individual's personnel file that supports the individual's academic program required at least 70% of its core curriculum be in the study of behavioral health or human behavior. Transcripts alone will not satisfy this requirement. A signed letter from the college or university stating the academic program required curriculum in which at least seventy percent (70%) of its required coursework was in the study of behavioral health or human behavior will satisfy the requirement. College or university published curriculum (may be published via college/university website) inclusive of required coursework demonstrating the program met the requirement is also acceptable.

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

Staff must also meet the following requirements:

1. Satisfactory completion of criminal background check pursuant to the BHSP licensing regulations (LAC 48:I.Chapter 56), La. R.S. 40:1203.1 et seq., La R.S. 15:587 (as applicable), and any applicable state or federal law or regulation;

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

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

4. Pass a motor vehicle screen;

5. Pass a TB test prior to employment;

6. Pass drug screening tests as required by agency's policies and procedures;

7. Complete American Heart Association (AHA) recognized First Aid, CPR and seizure assessment training. Psychiatrists, APRNs/CNSs/PAs, RNs and LPNs are exempt from this training. (See Appendix D);

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

9. Complete a nationally recognized crisis intervention training;

CI Allowed Provider Types and Specialties

- PT 77 Mental Health Rehab PS 78 MHR;
- PT 74 Mental Health Clinic PS 70 Clinic / Group PSS 8E CSoC/ Behavioral Health;
- PT AG Behavioral Health Rehabilitation Provider Agency PS 8E CSoC/ Behavioral Health.

CI Eligibility Criteria

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

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

CI Service Utilization

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

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

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

CI Allowed Mode(s) of Delivery

- Individual;
- On-site; and
- Off-site.

CI Additional Service Criteria

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

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

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

The CI provider must receive regularly scheduled clinical supervision from a person meeting the qualifications of an LMHP with experience regarding this specialized mental health service. The term "supervision" refers to clinical support, guidance and consultation afforded to non-licensed staff, and should not be confused with

clinical supervision of bachelor's or master's level individuals or provisionally licensed individuals pursuing licensure. Such individuals shall comply with current, applicable scope of practice and supervisory requirements identified by their respective licensing boards.