Clinical Policy: Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehab (PSR)

Reference Number: LA.CP.BH.90c
Date of Last Revision: 06/24

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

This policy is to define Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR) services for Louisiana Healthcare Connections members/enrollees, to define Provider Qualifications and Responsibilities for CPST and PSR Providers, and to establish medical necessity criteria to utilize for CPST and PSR Services. All CSPT and PSR 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.

A licensed mental health professional (LMHP) is an individual who is licensed in the State of Louisiana to diagnose and treat mental illness or substance use, acting within the scope of all applicable State laws and their professional license. An LMHP includes individuals licensed to practice *independently*. These provider types include:

- Medical psychologists
- Licensed psychologists
- Licensed clinical social workers (LCSWs)
- Licensed professional counselors (LPCs)
- Licensed marriage and family therapists (LMFTs)
- Licensed addiction counselors (LACs)
- Advanced practice registered nurses

Louisiana Healthcare Connections will determine if services are medically necessary based upon the clinical information supplied by the treating provider, including assessments, CALOCUS/LOCUS, Preliminary Treatment Goals or Treatment Plan, Outpatient Treatment Request (OTR) form, and supplemental information.

Rehabilitation services are provided as part of a comprehensive specialized psychiatric program available to all Louisiana Healthcare Connections eligible children, adolescents and adults with significant functional impairments resulting from an identified mental health disorder diagnosis to promote the maximum reduction of symptoms and restoration to his/her best age-appropriate functional level.

Provider Responsibilities

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

met. (See Section 2.6 of the LDH manual for Behavioral Health Services regarding record keeping)

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

III. Any licensed practitioner providing mental health services must operate within their scope of practice license.

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

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

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

VI. Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR) services provided by staff (holding an individual National Provider Identifier) regardless of employment at multiple agencies shall be limited to a maximum combined total of twelve (12) reimbursable hours of CPST services and PSR services within a calendar day.

- **A.** The twelve-(12) hour limitation shall not apply per individual behavioral health services provider agency, rather it applies per individual rendering provider;
- **B.** The twelve-(12) hour limitation shall not apply to evidence-based practices.
- **C.** There is a maximum combined total of twelve (12) reimbursable hours of CPST services and PSR services unless any of the following conditions are met:
  - **1.** The medical necessity of the services is documented through the prior authorization approval for a Medicaid recipient receiving more than twelve (12) hours of CPST and PSR services;
  - **2.** The services are billed for a group setting and the total hours worked by an individual rendering provider does not exceed twelve (12) hours per calendar day; or
  - **3.** The services are billed for crisis intervention

VII. Treatment Plan Oversight:

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

treatment plan review. The member/enrollee shall receive a signed copy of the plan upon completion and after each revision. A copy of the treatment plan should also be sent to all of the individuals involved in implementing and monitoring the treatment plan. This is necessary to ensure the member's or caregiver's agreement with the identified goals and objectives, ensure ongoing collaboration between the client and the LMHP, and to serve as a motivational strategy for the client. The treatment plan should not include services that are duplicative, unnecessary, or inappropriate.

VIII. Monitoring of Member Progress

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

1. Assessing mental health symptoms.

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

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

IX. Staff Supervision for Non-Licensed Staff

A. Provisionally Licensed Professional Counselor (PLPC), Provisionally Licensed Marriage and Family Therapist (PLMFT), Licensed Master Social Worker (LMSW), Certified Social Worker (CSW) or a psychology intern from an APA (American Psychological Association) approved internship program delivering CPST and/or PSR, services must be under regularly scheduled supervision in accordance with requirements established by the practitioner's professional licensing board. Proof of the board approved supervision must be held by the MHR agency employing these staff. For the psychology intern, the supervisory plan is acceptable. In addition, these staff who only provide CPST or PSR must receive at least one hour per calendar month of personal supervision and training by the provider agency's mental health supervisor pursuant to La. R.S. 40:2162, et seq. and must be documented according to the requirements listed in numbers 2 and 3 below. Non-licensed staff providing PSR (excluding psychology interns) must receive regularly scheduled supervision from a person meeting the qualifications of a psychiatrist or an LMHP (excluding Licensed Addiction Counselors (LACs). Mental Health supervisors must have the practice-specific education, experience, training, credentials, and licensure to coordinate an array of mental and/or behavioral health services. Agencies may have more than one supervisor providing required supervision to non-licensed staff. However, the agency must designate one Clinical Supervisor to fulfill the roles and responsibilities established for the Clinical Supervisor

position in the Core Staffing section above. A supervisor may act in the role of the provider agency's Clinical Supervisor if the individual is qualified to fulfill both roles. Supervision refers to clinical support, guidance and consultation afforded to non-licensed staff rendering rehabilitation services and should not be replaced by licensure supervision of master's level individuals pursuing licensure. Effective July 15, 2020, staff must receive a minimum of four (4) hours of clinical supervision per month for full time staff and a minimum of one (1) hour of clinical supervision per month for part time staff, that must consist of no less than one (1) hour of individual supervision. Each month, the remaining hours of supervision may be in a group setting. Given consideration of case load and acuity, additional supervision may be indicated. The LMHP (excluding LACs) supervisor must ensure services are in compliance with the established and approved treatment plan. Group supervision means one LMHP supervisor (excluding LACs) and not more than six (6) supervisees in supervision session. Texts and/or emails cannot be used as a form of supervision to satisfy this requirement. All protected health information discussed during supervision must be HIPAA compliant. The supervision with the LMHP must:

1. Occur before initial services on a new member begin and, at a minimum, twice a month preferably every fifteen (15) days (except under extenuating or emergent circumstances that are reflected in the supervisory notes)

2. Progress notes that are discussed in supervision must have the LMHP supervisor signature.

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

a) Date and duration of supervision.

b) Identification of supervision type as individual or group supervision.

c) Name and licensure credentials of the LMHP supervisor.

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

e) The focus of the session and subsequent actions that the supervisee must take.

f) Date and signature of the LMHP supervisor.

g) Date and signature of the supervisees.

h) Member identifier, service and date range of cases reviewed.

i) Start and end time of each supervision session.

Services Definitions

I. Services for Children and Adolescents

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

1. Restoration of positive family/caregiver relationships;

2. Prosocial peer relationships;

3. Community connectedness/social belonging; and

4. The ability to function in a developmentally appropriate home, school, vocational and community settings.

B. Children/adolescents who are in need of specialized behavioral health services shall be served within the context of the family to assure that family dynamics are addressed and are a primary part of the treatment plan and approach. While a child/adolescent is receiving rehabilitation services, a parent/caregiver and necessary family members/enrollees should be involved in medically necessary services. The treatment plan and progress notes must indicate the member/enrollee's parent/caregiver and family are involved in treatment. When clinically and developmentally appropriate (for instance, when providing services to an adolescent), services may be delivered without the parent/caregiver present, as long as the above standards of parent/caregiver involvement are met throughout treatment. However, particularly when services are delivered to younger children, the majority of the services should be delivered with parent/caregiver participating with the member/enrollee as the services are delivered, as the most developmentally appropriate, clinically effective service will be delivered with the full engagement and participation of the parent/caregiver. Following initial authorization, if a member/enrollee is not progressing and the family is not engaged or participating in treatment, the treatment plan and approach should be updated to assure family involvement before reauthorization is considered. Services should provide skills building and supports that build on existing strengths and target goals related to these key developmental needs and protective factors.

II. Services for Adults

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

B. Rehabilitation services are expected to achieve the following outcomes:

1. Assist individuals in the stabilization of acute symptoms of illness

2. Assist individuals in coping with chronic symptoms of their illness.

3. Minimize the aspects of their illness which makes it difficult for persons to live independently.

4. Reduce or prevent psychiatric hospitalizations.

5. Identify and develop strengths; and

6. Focus on recovery (see LDH Behavioral Health Provider Manual section 2.3 Outpatient Services-for a detailed description of National Consensus Statement on Recovery and the components of recovery)

Prior Authorization Process

I. Request for services will be authorized for up to 60 days of services at a time.

II. The Plan requires the following documentation to be submitted by the provider when requesting initial CPST/PSR services:

- **A.** Outpatient Treatment Request (OTR) form
- **B.** CALOCUS/LOCUS (appropriate to the member/enrollee's age)
  - **1.** CALOCUS – Members/enrollees ages 6 – 18
  - **2.** LOCUS – Members/enrollees ages 19 and older
- **C.** Providers must also submit CALOCUS/LOCUS ratings on a form that includes the rating in each dimension, the criteria to support the rating, independent criteria, the composite score, the level of care, a section to document notes, a signature line with credentials, and a rating date. A sample rating form is on page 48 of the CALOCUS manual.
- **D.**
- **E.** Required Assessments-Each member/enrollee shall be assessed and shall have a treatment plan developed based on that assessment.
  - **1.** Assessments shall be performed by an LMHP, and for children and adolescents shall be completed with the involvement of the primary caregiver.
  - **2.** For adults, assessments must be performed prior to receiving CPST and/or PSR and at least once every 365 days until discharge. Assessments must also be performed any time there is a significant change to the member/enrollee's circumstances.
  - **3.** 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/enrollee's circumstances.
- **F.** The intensity, frequency, and duration for any service must be individualized.
- **G.** Preliminary Treatment Goals identified by CALOCUS/LOCUS assessment needs
- **H.** Homebuilders approval, if applicable
- **I.** Additional supporting documentation, if applicable
- **J.** Member Freedom of Choice Form.
  - **1.** All members/enrollees must complete and sign a Member Choice Form prior to the start of CPST/PSR services and when transferring from one CPST/PSR provider to another.
  - **2.** The Member Choice Form must be fully completed, signed by all parties, and received by the member/enrollee's health plan prior to the start of services.
  - **3.** The Member Choice Form is required to be part of the member/enrollee's clinical record and subject to audit upon request.
  - **4.** LHCC will monitor this process and ensure no overlapping authorizations occur unless it is during a planned transition.
    - **a)** Upon a requested transfer, the initial provider will be provided a written notification of the updated dates of service, and the updated number of units authorized. The new provider will be given a start date by

the member's health plan to ensure providers are reimbursed for services delivered.

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

a) A member/enrollee is receiving tenancy support through the Permanent Supportive Housing Program, and/or

b) LHCC's Behavioral Health Medical Advisor makes the determination that it is medically necessary and clinically appropriate to receive services from more than one MHR provider (and all requirements in the LDH Behavioral Health Provider Manual are met).

III. The Plan requires the following documentation to be submitted by the provider when requesting continuation of CPST/PSR services:

A. OTR form

B. CALOCUS/LOCUS (appropriate to the member/enrollee's age)

C. Comprehensive Treatment Plan - Treatment plans shall be based on the member/enrollee's assessed needs and developed by an LMHP or physician in collaboration with direct care staff, the member/enrollee, family and natural supports. The treatment plan shall contain goals and interventions targeting areas of risk and need identified in the assessment. All team members/enrollees, including the member/enrollee and family, shall sign the treatment plan. The member/enrollee shall receive a copy of the plan upon completion. (If the member/enrollee is too young to sign the treatment plan, a caregiver signature is sufficient to sign and receive the treatment plan) by all required parties and a copy given to the member/enrollee/guardian. The goal of the treatment plan is to help ensure measurable improved outcomes, increased strengths, a reduction in risk of harm to self or others, and a reduction emergency department use or in the risk of out of home placements to inpatient and residential care. Based on an assessment/reassessment and informed by the member/enrollee, parent/caregiver, the written treatment plan must include the following:

1. Goals and objectives that are specific, measurable, action oriented, realistic, and time-limited;

2. Specific interventions based on the assessed needs that must include reference to training material when delivering skills training;

3. Frequency and duration of services that will enable the member/enrollee to meet the goals and outcomes identified in the treatment plan

4. Services and interventions to support independent community living for transitioning adolescents and adults in the setting of his or her own choice and must support integration in the community, including opportunities to seek employment, engage in community life, control personal resources, and improve functional skills at school, home or in the community.

5. Member/enrollee's strengths, capacities, and preferences;

6. Clinical and support needs that are indicated by a psychosocial assessment, Child and Adolescent Level of Care Utilization System (CALOCUS) or Level of Care Utilization System (LOCUS) rating and other standardized assessment tools as clinically indicated

7. Place of service(s) for each intervention- The following are required when services are delivered at school

a) The initial and ongoing assessment must indicate school related needs, which may include, but is not limited to, disruptive behaviors in school, poor school attendance, and difficulties with social and peer interactions in school;

b) Prior to services being delivered in the school setting, each member/enrollee shall be assessed by an LMHP. This assessment shall include a review of school records and interviews with school personnel. Ongoing reassessment of need shall be conducted by an LMHP to determine if services shall continue with school as a place of service.

c) Providers shall collaborate with school personnel to collect data to monitor a member/enrollee's progress. Data collection may include standardized tools as well as collecting other information to determine if a member/enrollee is making progress. This shall be documented in the member/enrollee's record. Data collection is not billable.

d) The member/enrollee shall not be removed from a core class such as math, science, or English, without written permission from the parent and school personnel. A rationale shall be documented in the member/enrollee's record. If allowed by the member/enrollee's school, direct interventions may be delivered in the classroom if medically necessary and on the member/enrollee's treatment plan. Only observing a member/enrollee is not billable.

e) Prior to delivering services in a member/enrollee's school, the provider shall obtain written approval from the school. The written approval shall be filed in the member/enrollee's record.

f) Providers delivering services in a member/enrollee's school shall actively communicate and coordinate services with school personnel and with the member/enrollee's family/caregiver to avoid service duplication.

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

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

8. Staff type delivering each intervention.

9. Crisis avoidance interventions including the identification of risk factors and barriers with strategies to overcome them, including individualized back-up plans.

10. Language written in a way that is clearly understandable by the member/enrollee

11. Homebuilders' approval, if applicable

12. Additional supporting documentation, if applicable, indicating:

a) Member/enrollee's progress or lack of progress in treatment,

b) Interventions that have or have not worked to improve Member/enrollee's presentation

c) Current symptoms and how they impact the member/enrollee's current functioning

IV. Treatment Plans will be updated every 180 days based upon assessment needs from CALOCUS/LOCUS for all members/enrollees

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

B. The member/enrollee shall receive a signed copy of the plan upon completion and after each revision. A copy of the treatment plan should also be sent to all of the individuals involved in implementing and monitoring the treatment plan as described in Provider Responsibilities, Treatment Plan Oversight Section.

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

1. Assessing mental health symptoms; and

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

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

VI. The Plan encourages and promotes the use of **evidenced-based practices (EBP).**

A. If a member/enrollee is identified as potentially being able to benefit from and meeting medical necessity criteria for evidence-based treatment, and EBPs are available to the recipient, the Plan will deny the CPST/PSR services and will authorize the identified EBP (more appropriate level of care) through the same agency or facilitate recipient transfer to an available provider who can meet the needs of the member/enrollee.

B. If a member/enrollee is identified as potentially being able to benefit from an evidence-based treatment but unable to access EBPs, the Plan will approve the CPST/PSR services when the MHR provider's documentation includes all of the following:

1. A pre and post evaluation of treatment with each authorization request

2. The utilization of a standard and consistent tool to evaluate progress toward treatment goals

C. If the member/enrollee is demonstrating progress toward goals without EBP, the Plan will continue authorizing the requested services through the established authorization process.

D. If the member/enrollee fails to progress after a reasonable timeframe, the Medical Advisor will review the clinical documentation, and offer a peer-to-peer discussion, and will then render a determination based upon all of the available clinical information. An adverse determination letter will be sent to the member/enrollee and provider communicating the decision of a full or partial denial to the provider along with a recommendation for a more appropriate level of care if needed.

1. The Plan allows for reasonable coverage of services at one level of care while providers are working with the Health Plan to transition a member/enrollee to the next level of care. Continued services will be allowed for a minimum of 1 week and up to a maximum of 2 weeks (at the discretion of the Plan Medical Advisor) to allow for the appropriate transition to the next level of care. The Adverse Determination letter will also indicate the specific reason for the denial and the timeframe allowed for the transition of care as specified in LA.UM.07 *Adverse Determination (Denial) Notices*.

Medical Necessity Criteria

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

I. Community Psychiatric Support and Treatment (CPST)

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

treatment. CPST services should be focused on the individual's ability to succeed in the community; to identify and access needed services; and to show improvement in school, work and family function. CPST is a face-to-face intervention with the individual present; however, family or other collaterals may also be involved. Most contacts occur in community locations where the person lives, works, attends school and/or socializes. Services must be provided in locations that meet the needs of the persons served.

B. 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 meeting the definition of an LMHP as detailed in this policy's description. 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.

C. Components

1. Performed by an LMHP

a) Initial and annual assessment, including the LOCUS/CALOCUS

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

2. Performed by an LMHP or other qualified professional (see staff requirements below)

a) Ongoing monitoring of needs including triggering an update of the treatment plan by the LMHP if needs change significantly;

b) Counseling, including mental health interventions that address symptoms, behaviors, thought processes, that assist the member/enrollee in eliminating barriers to treatment and identifying triggers. Counseling includes assisting the member/enrollee with effectively responding to or avoiding identified precursors or triggers that would impact the member/enrollee's ability to remain in a natural community location. The use of evidenced based practices/strategies is encouraged

c) Clinical psycho-education includes using therapeutic interventions to provide information and support to better understand and cope with the illness. The illness is the object of treatment, not the family. The goal is for therapist, members/enrollees, and families work together to support recovery, including assisting the individual and family members/enrollees or other collaterals with identifying a potential psychiatric or personal crisis.

3. Staff Requirements:

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

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

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

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

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

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

(5) Direct care staff must not have a finding on the Louisiana State Adverse Action List;

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

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

(8) Individuals rendering CPST services for the licensed and accredited provider agency must have an NPI number and that NPI number must be included on any claim submitted by that provider agency for reimbursement.

D. Admission – Severity of Need: Criteria 1 through 3 must be met:

1. The member/enrollee is unable to maintain an adequate level of functioning without this service due to a Psychiatric disorder as evidenced by (must meet a and either b or c):

a) Severe symptoms and/or history of severe symptoms for a significant duration, and

b) Impairment in performance of the activities of daily living, and/or

c) Significant disability of functioning in at least one major life area including social, occupational, living and/or learning.

2. The member/enrollee seeks and actively participates in a joint provider/member/enrollee assessment and the provider/member/enrollee jointly agree that the member/enrollee desires, is committed to, and will likely benefit from the supportive/rehabilitation process. Documentation of member/enrollee

assessment and demonstration of potential member/enrollee benefit will be sufficient when there is evidence that provider is working on member/enrollee engagement.

3. The interventions necessary to stabilize, the member/enrollee's behaviors, symptoms, and ability to function related to their psychiatric disorder requires the frequency, intensity and duration of contact provided by the CPST provider as evidenced by:

a) Failure to stabilize, progress, or improve functioning with a less intensive intervention, and/or

b) Need for specialized intervention for a specific impairment or disorder.

E. Admission – Intensity and Quality of Service Criteria 1 through 6 must be met

1. Assist the individual and family members/enrollees or other collaterals to identify strategies or treatment options associated with the individual's mental illness, with the goal of minimizing the negative effects of Mental Health emotional disturbances or associated environmental stressors which interfere with the individual's daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships and community integration.

2. Provide individual supportive counseling, solution-focused interventions, emotional and behavioral management and problem behavior analysis to the individual, with the goal of assisting the individual with developing and implementing social, interpersonal, self-care, daily living and independent living skills to restore stability, to support functional gains and to adapt to community living.

3. Participation in and utilization of, strengths-based planning and treatments, which include assisting the individual and family members/enrollees or other collaterals with identifying strengths and needs, resources, natural supports and developing goals and objectives to utilize personal strengths, resources and natural supports to address functional deficits associated with their mental illness.

4. Assist the individual with effectively responding to or avoiding identified precursors or triggers that would risk him or her remaining in a natural community location, including assisting the individual and family members/enrollees or other collaterals with identifying a potential psychiatric or personal crisis, developing a crisis management plan and/or, as appropriate, seeking other supports to restore stability and functioning.

5. Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the youth's medical record. The provider shall participate in Team meetings and/or conferences with other child-serving entities (i.e.; DCFS, OCDD, CSoC, MCO, Juvenile Justice System, etc.)

6. The provider shall make every effort to participate in regularly scheduled Child and Family Team meetings with the child/youth and family/natural supports as best practice.

F. **Continued Stay** Criteria 1 through 4 must be met:

1. The member/enrollee continues to meet admission criteria.

a) An adult with longstanding deficits who does not experience any acute changes in their status and has previously met the criteria stated above regarding LOCUS scores, but who now meets a level of care of two or lower on the LOCUS, and needs subsequent medically necessary services for stabilization and maintenance at a lower intensity, may continue to receive CPST services and/or PSR, if deemed medically necessary

2. Recovery requires a continuation of these services.

3. Member/enrollee, and family (when available and included in the treatment plan) are making progress toward goals and actively participating in the interventions. In the instance of limited or no progress, there must be documented evidence of changes in the treatment plan, efforts to engage the member/enrollee and/or family, or some other action to address the lack of progress.

4. There is a reasonable likelihood of continued substantial benefit as a result of active continuation of the services, as demonstrated by objective behavioral/functional measurements of improvement.

a) Members must be expected to improve at this current level of service, and

b) Member has not yet achieved the maximum benefit at the requested level of service

G. Telehealth

1. For dates of service on or after May 1, 2023, telemedicine/telehealth is the use of a telecommunications system to render healthcare services when a physician, LMHP, or other qualified professional (see staff qualifications) and a member are not in the same location. Telehealth does NOT include the use of text, e-mail, or facsimile (fax) for the delivery of healthcare services. The originating site means the location of the member at the time the telehealth services are provided. There is no restriction on the originating site and it can include, but is not limited to, a healthcare facility, school, or the member's home. Distant site means the site at which the physician or other licensed practitioner is located at the time the telehealth services are provided. CPST may be provided via telecommunication technology when the following criteria is met:

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

b) The services provided are within the practitioner's telehealth scope of practice as dictated by the respective professional licensing board and accepted standards of clinical practice;

c) The member's record includes informed consent for services provided through the use of telehealth;

d) Services provided using telehealth must be identified on claims submission using by appending the modifier "95" to the applicable procedure code and indicating the correct place of service, either POS 02 (other than home) or 10 (home). Both the correct POS and the 95 modifier must be present on the claim to receive reimbursement;

e) Assessments and treatment planning conducted by an LMHP through telehealth shall include synchronous, interactive, real-time electronic communication comprising both audio and visual elements unless clinically appropriate and based on member consent; and

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

II. Psychosocial Rehabilitation (PSR)

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

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

C. Components

1. Skills building includes the practice and reinforcement of independent living skills, use of community resources and daily self-care routines. The primary focus is to increase the basic skills that promote independent functioning so the member/enrollee can remain in a natural community location and achieve developmentally appropriate functioning, and assisting the member/enrollee with effectively responding to or avoiding identified precursors or triggers that result in functional impairment.

2. Supporting the restoration and rehabilitation of social and interpersonal skills to increase community tenure, enhance personal relationships, establish support networks, increase community awareness, develop coping strategies and effective functioning in the individual's social environment, including home, work and school

3. Supporting the restoration and rehabilitation of daily living skills to improve self-management of the negative effects of psychiatric or emotional symptoms that interfere with a person's daily living. Supporting the individual

with development and implementation of daily living skills and daily routines necessary to remain in home, school, work and community.

D. Staff Requirements-

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

2. To provide psychosocial rehabilitation services, staff must meet the following requirements:

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

(1) Have a bachelor's degree from an accredited university or college in the field of counseling, social work, psychology, sociology, rehabilitation services, special education, early childhood education, secondary education, family and consumer sciences, criminal justice, or human growth and development; or

(2) Have a bachelor's degree from an accredited university or college with a minor in counseling, social work, sociology, or psychology; or

(3) Be twenty-one (21) years of age or older as of January 1, 2022, have a high school diploma or equivalency, and have been continuously employed by a licensed and accredited agency providing PSR services since prior to January 1, 2019

b) 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;

c) 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;

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

e) Pass drug screening tests as required by agency's policies and procedures.

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

g) Non-licensed direct care staff are required to complete a basic clinical competency training program approved by the Office of Behavioral Health (OBH) prior to providing the service

h) Individuals rendering PSR services for the licensed and accredited provider agency must have an NPI number and that NPI number must be included on any claim submitted by that provider agency for reimbursement

E. **Admission - Severity of Need:** Criteria 1 through 3 must be met:

1. Diagnosable mental health disorder that the condition must substantially interfere with the role, occupational and social functioning. The level of functioning without this service due to a psychiatric disorder as evidenced by (must meet a and either b or c):

a) Severe symptoms and/or recent history of severe symptoms for a significant duration, and

b) Impairment in performance of the activities of daily living, and/or

c) Significant disability of functioning in at least one major life area including social, occupational, living and/or learning.

2. The member/enrollee seeks and actively participates in a joint provider/member/enrollee assessment and the provider/member/enrollee jointly agree that the member/enrollee desires, is committed to, will likely benefit from the rehabilitation process.

3. The interventions necessary to stabilize the member/enrollee's behaviors, symptoms, and ability to function related to their psychiatric disorder requires the frequency, intensity and duration of contact provided by the rehabilitative service as evidenced by:

a) Failure to reverse/stabilize/progress with a less intensive intervention, and/or

b) Need for specialized intervention for a specific impairment or disorder.

F. Admission – Intensity and Quality of Service Criteria 1 through 5 must be met.

1. Services are to develop social and interpersonal skills to increase community tenure, enhance personal relationships, establish support networks, increase community awareness, develop coping strategies and effective functioning in the individual's social environment, including home, work and school.

2. Services are to develop daily living skills to improve self-management of the negative effects of psychiatric or emotional symptoms that interfere with a person's daily living. Supporting the individual with development and implementation of daily living skills and daily routines necessary to remain in home, school, work and community.

3. Services restore learned skills so the person can remain in a natural community location and achieve developmentally appropriate functioning.

4. Services are to assist the individual with effectively responding to or avoiding identified precursors or triggers that result in functional impairments.

5. Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the youth's medical record.

a) The provider shall make every effort to participate in any regularly scheduled Team meetings and/or conferences with other child-serving entities (i.e.; DCFS, OCDD, CSoC, MCO, Juvenile Justice System, etc.) and with the child/youth and family/natural supports as best practice.

G. **Continued Stay** Criteria 1 through 3 must be met.

1. An assessment appropriate to the recovery model indicates at least one of the following:

a) As a result of the psychiatric diagnosis, there are or continue to be functional impairments and skill deficits which are effectively addressed in the individualized treatment plan. In the event that earlier efforts have not achieved the intended objectives, the revised plan indicates service modifications to address these issues, or

b) There is a reasonable expectation that the withdrawal of services may result in loss of rehabilitation gains or goals attained by the member/enrollee, or

c) It has been identified that the member/enrollee requires a different level of care or service and additional time is needed with the current mental health provider to effectively implement a transition plan to ensure continuity of care.

2. The reasonable likelihood of substantial benefit as a result of active continuation of the services, as demonstrated by objective behavioral/functional measurements of improvement.

a) Members must be expected to improve at this current level of service, and

b) Member has not yet achieved the maximum benefit at the requested level of service

3. The member/enrollee/family chooses to continue in the program.

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

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

B. Adults must meet the Substance Abuse and Mental Health Services Administration (SAMHSA) definition of, serious mental illness (SMI) as evidenced by a rating of three or greater on the functional status domain on the Level of Care Utilization System (LOCUS) rating. In addition to having a diagnosable mental disorder, the condition must substantially interfere with, or limit, one or more major life activities, such as:

1. Basic daily living (for example, eating or dressing);

2. Instrumental living (for example, taking prescribed medications or getting around the community); and

3. Participating in a family, school, or workplace.

C. An adult with longstanding deficits who does not experience any acute changes in their status and has previously met the criteria stated above regarding LOCUS scores, but who now meets a level of care of two or lower on the LOCUS, and needs subsequent medically necessary services for stabilization and maintenance at a lower intensity, may continue to receive CPST services and/or PSR, if deemed medically necessary.

IV. Limitations/Exclusions - The following services shall be excluded from LHCC coverage and reimbursement:

A. Any adult with a diagnosis of substance use disorder or intellectual/developmental disability without an additional co-occurring qualifying mental health diagnosis.

B. Components that are not provided to, or directed exclusively toward, the treatment of the Medicaid eligible individual.

C. Services provided at a work site which are job tasks oriented and not directly related to the treatment of the member/enrollee's needs.

D. These rehabilitation services shall not duplicate any other Medicaid State Plan service or service otherwise available to the member/enrollee at no cost.

E. Any services or components in which the basic nature of which are to supplant housekeeping, homemaking, or basic services for the convenience of an individual receiving services.

F. Services shall not be provided at an institute for mental disease (IMD).

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

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

2. Childcare provided as a substitute for the parent or other individuals responsible for providing care and supervision;

3. Respite care;

4. Teaching job related skills (management of symptoms and appropriate work habits may be taught);

5. Vocational rehabilitation (vocational assessment, job development, job coaching); CPST and PSR can include services, such as interpersonal skills, anger management, etc.) that enable the beneficiary to function in the workplace;

6. Transportation

7. Staff training

8. Phone contacts including attempts to reach the member/enrollee by telephone to schedule, confirm, or cancel appointments;

9. Staff supervision

10. Completion of paperwork when the member/enrollee and/or their significant others are not present. Requiring members/enrollees to be present only for documentation purposes is not reimbursable

11. Team meetings and collaboration exclusively with staff employed or contracted by the provider where the member/enrollee and/or their family/caregivers are not present;

12. Observation of the member/enrollee (e.g. in the school setting or classroom);

13. Staff research on behalf of the member/enrollee;

14. Providers may not set up summer camps and bill the time as a mental health rehabilitation service;

15. All contacts by salaried professionals such as supervisors, administrators, human resources staff, receptionists, etc. that are included in the rate (including meetings, travel time, etc.), are considered indirect costs;

16. Contacts that are not medically necessary

17. Covered services that have not been rendered;
18. Services rendered that are not in accordance with an approved authorization;
19. Interventions not identified in the member/enrollee's treatment plan
20. Services provided to children, spouse, parents, or siblings of the eligible member/enrollee under treatment or others in the eligible member/enrollee's life to address problems not directly related to the eligible member/enrollee's issues and not listed on the member/enrollee's treatment plan;
21. Services provided that are not within the provider's scope of practice;
22. Any art, movement, dance, or drama therapies; and
23. Any intervention or contact not documented.

CPT/HCPCS Codes	Modifiers
96156- Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)	TG, U8
H0036- Community psychiatric supportive treatment, face-to-face, per 15 minutes	TG, U8
H2022- Community-based wrap-around services, per diem	HQ, TG, U8

Reviews, Revisions, and Approvals	Revision Date	Approval Date	Effective Date
Original approval date	5/18		
• Service Delivery Section: added LDH update • Assessment and Treatment Planning Section: added LDH updates regarding CA/LOCUS and CA/LOUCS manual language regarding when additional assessments are needed. • Prior Authorization process section B: added clarification of what additional information is required for auth requests. • Prior Authorization process section C: Removed allowance of a request over the 60 day standard auth period as MHR auths are only given for 60 days. • Removed UM Staff and replaced with Adverse Determination Letter in Prior Auth Section D and E.	5/19		
• Updated scope to include Louisiana Healthcare Connections • Grammatical changes • Formatting changes • Removed language that is located in the LDH BH Provider Manual • Changed LHCC to The Plan • Updated Prior Auth process • Changed Medical Director to Medical Advisor • Added Goals of PSR	4/20		

Reviews, Revisions, and Approvals	Revision Date	Approval Date	Effective Date
• Updated references			
• Removed promoting maximum reduction of symptoms • Changed Section 2.3 Outpatient for National Consensus Statement on Recovery to 2.3 Outpatient Services • Moved Locus score of 2 down to MNC criteria • Changed services teach to services restore learned skills • Changed psychiatric rehabilitation plan to individualized treatment plan • Add Adult MNC Criteria • Updated Treatment plan information as changes were made to LDH provider manual	6/20		
• Annual Review – No Changes	05/21		
• Revisions made based on updates from LDH provider manual • Changed member to member/enrollee • Changed Last Revision Date to Date of Last Revision in header • Changed Date to Revision Date in Revision Log • Reformatted policy for easier readability	5/23	7/21/23	
Annual Review. References Reviewed and Updated. Added section C. under prior authorization process. Section G. Under Medical Necessity Criteria for Tele Health added.	07/24	10/23/24	11/22/24

References

1. Louisiana Department of Health Behavioral Health Services Provider Manual
2. Louisiana Behavioral Health Partnership Service Definitions Manual Version 8
3. LA.UM.07Adverse Determination (Denial) Notices

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering

benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. LHCC retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom LHCC has no control or right of control. Providers are not agents or employees of LHCC.

This clinical policy is the property of LHCC. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.