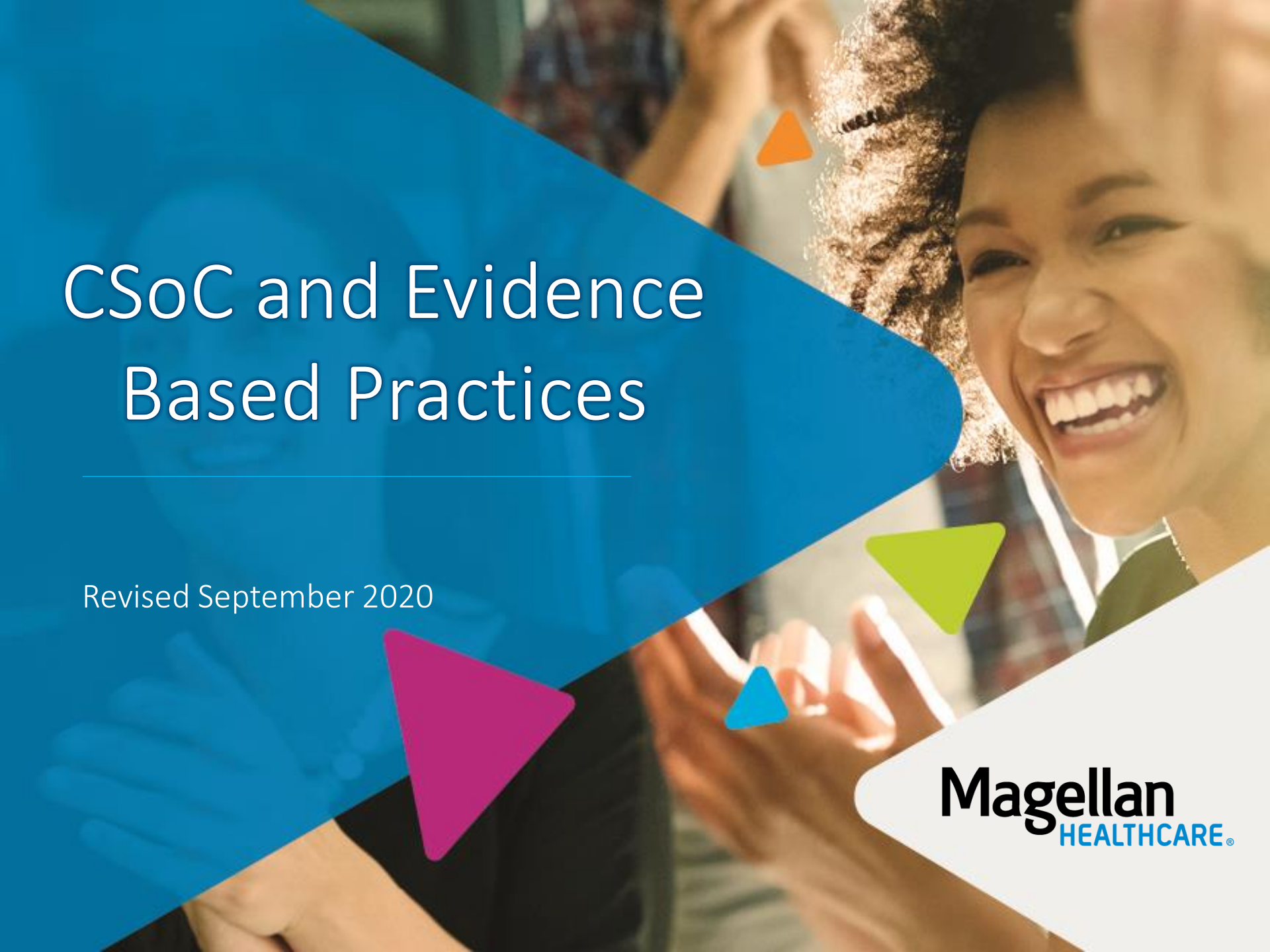
CSoC and Evidence Based Practices

Revised September 2020



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Coordinated System of Care (CSoC)

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Coordinated System of Care

The Coordinated System of Care (CSoC) is for Louisiana's children and youth with significant behavioral health challenges or co-occurring disorders that are in or at imminent risk of out of home placement.

- The CSoC is an evidence-informed approach to family and youth-driven care that enables children to successfully live at home, stay in school and reduce involvement in the child welfare and juvenile justice systems. The primary goals for CSoC include:
  - Reducing the number of children and youth in detention and residential settings;
  - Reducing the State's cost of providing services by leveraging Medicaid and other funding sources;
  - Increasing access to a fuller array of home and community-based services that promote hope, recovery and resilience;
  - Improving quality by establishing and measuring outcomes; and
  - Improving the overall functioning of these children and their caregivers.
- A child/youth eligible for CSoC will meet the following criteria:
  - Ages 5 through 20
  - DSM 5 diagnosis
  - Meets clinical eligibility for CSoC as determined by the Child and Adolescent Needs and Strengths (CANS) Comprehensive scale
- Anyone with concerns about a child/youth's behaviors may assist the parent/guardian on making a referral to CSoC
- If the child/youth passes the screening, referral is made to the Wraparound agency (WAA) and the Family Support Organization (FSO)

Coordinated System of Care - WAA

Wraparound

- Is an intensive, individualized, team based care planning and management process that is used to achieve positive outcomes by providing a structured, creative and team-based planning process that addresses the needs of the child/youth and their family.
- The cornerstone of the wraparound process is that it is driven by the goals, perspectives, and preferences of the child/youth and their family as they work side by side with the wraparound facilitator and the other members of the Child and Family Team.
- Through this team-based collaborative approach, a single Plan of Care is developed that focuses on the strengths of the child/youth, family and other team members rather than the deficits. This single comprehensive plan encompasses both formal and informal services. During the regularly scheduled Child and Family Team meetings, the plan is reviewed and changes are made as needed so that the child/youth and family achieve their goals.

- The Wraparound Agency (WAA) is responsible for ensuring the implementation of the wraparound process

- The Wraparound Facilitator (WF), in the WAA, is responsible for working with the family throughout their participation in CSoC. Responsibilities of the WF include, but are not limited to:
  - Meeting with the child/youth/family to complete the Strengths, Needs and Cultural Discovery;
  - Assisting the family in identifying and developing a Family Vision, Strengths, Goals, create a family story, etc.;
  - Assisting the child/youth/family in identifying potential members of the Child and Family Team (CFT), which should include formal and informal supports including providers;
  - Convening and facilitating the CFT meetings on a monthly basis at a minimum and more frequently whenever needed; and
  - Facilitating the development and implementation of the Plan of Care (POC), which includes a Crisis Plan. The Plan of Care will include formal and informal supports and services the Child and Family Team deem appropriate.

Family Support Organization (FSO)

- Provides Parent Support and Training and Youth Support and Training which are two of the specialized services for youth enrolled in CSoC

- Responsibilities of the FSO include, but are not limited to:
  - Ensure appropriate screening, hiring, training processes are in place for each FSO staff person;
  - Develop a cadre of Parent Support and Training (PST) and Youth Support and Training (YST) staff in each region;
  - Establish a centralized intake process for all requests for FSO services;
  - Receive referrals for FSO services (PST/YST) from the CSoC Contractor or the WAA when immediate and routine needs are identified;
  - Attend Child and Family Team (CFT) meetings as requested by the families receiving FSO services;
  - Provide PST/YST services in accordance with the family's Plan of Care;
  - Participate in the Statewide Coordinating Council;
  - Develop active partnerships and effective working relationships with all WAA staff;
  - Actively partner with the State, the CSoC Contractor, and regionally-based WAA staff to promote the values of CSoC and the value of wraparound

Assertive Community Treatment (ACT)

Assertive Community Treatment

Assertive Community Treatment (ACT) services are community-based therapeutic interventions that address the functional problems of members who have the most complex and/or pervasive conditions associated with serious mental illness. These interventions are strength-based and focused on supporting recovery through the restoration of functional daily living skills, building strengths, increasing independence, developing social connections, and leisure opportunities, and reducing the symptoms of their illness. Through these activities, the goal is to increase the members ability to cope and relate to others while enhancing the member's highest level of functioning in the community.

Assertive Community Treatment Continued

Interventions may address adaptive and recovery skill areas. These include, but are not limited to, supportive interventions to help maintain housing and other employment, daily activities, health and safety, medication support, harm reduction, money management, entitlements, service planning, and coordination.

Target Population

ACT serves CSoC members - eighteen (18) years old or older who have a severe and persistent mental illness (SPMI) and members with co-occurring disorders listed in the diagnostic nomenclature (current diagnosis per DSM) that seriously impairs their functioning in the community.

The member must have one of the following diagnoses:

* Schizophrenia;
* Other psychotic disorder;
* Bipolar disorder; and/or
* Major depressive disorder.

These may also be accompanied by any of the following:

* Substance use disorder; or
* Developmental disability.

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Provider Qualifications and Responsibilities

The MCO may contract with ACT teams meeting national fidelity standards as evidenced by the SAMHSA Assertive Community Treatment (ACT) Evidence-Based Practices (EBP) Toolkit.

ACT agencies must be licensed pursuant to La. R.S. 40:2151, et. seq. for behavioral health service providers and accredited by an LDH approved national accrediting body: Commission on Accreditation of Rehabilitation Facilities (CARF), 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 by the accrediting body of such denial, loss of, or any negative change in accreditation status to the managed care entities with which the ACT agency contracts or is reimbursed.

NOTE: Effective March 14, 2017, ACT agencies must apply for accreditation and pay accreditation fees prior to being contracted with or reimbursed by a Medicaid managed care entity, and must maintain proof of accreditation application and fee payment. ACT agencies must attain full accreditation within eighteen (18) months of the initial accreditation application date. ACT Agencies contracted with a managed care entity prior to March 14, 2017, must have attained full accreditation by September 14, 2018, i.e. eighteen (18) months from the initial effective date of the requirement for ACT agencies.

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Provider Qualifications and Responsibilities Continued

The provider agency must meet all qualifications as required for other outpatient and rehabilitation agencies and must maintain documentation and verification of licensure, accreditation, staff criminal background checks, TB testing, drug testing, evidence of fidelity to the model (via SAMHSA ACT EBP Toolkit) and required training for staff employed or contracted with the agency.

ACT agencies must adhere to all requirements established in the Provider Responsibilities section located in the Outpatient Services: Rehabilitation Services chapter of the Behavioral Health Services Provider Manual. Please refer to that section for specific information on all provider responsibilities.

Each ACT team shall have sufficient numbers of staff to provide treatment, rehabilitation and support services twenty-four (24) hours a day, seven (7) days per week. Each ACT team shall have the capacity to provide the frequency and duration of staff-to-program member contact required by each member's treatment plan.

Each ACT team shall have the capacity to increase and decrease contacts based upon daily knowledge of the member's clinical need, with a goal of maximizing independence. The team shall have the capacity to provide multiple contacts to persons in high need and a rapid response to early signs of relapse. The nature and intensity of ACT services are adjusted through the process of daily team meetings.

Provider Qualifications and Responsibilities Continued

Each ACT team shall have a staff-to-member ratio that does not exceed 1:10. Any ACT team vacancies that occur will be filled in a timely manner to ensure that these ratios are maintained.

All professional staff must be currently and appropriately licensed by the applicable professional board. Prior to providing the service, each staff member receives training on the skills and competencies necessary to provide ACT services.

Each staff member must meet the required skills and competencies within six months of their employment on an ACT team. Successful completion of LDH-approved trainings can satisfy this requirement.

Provider Qualifications and Responsibilities Continued

Each ACT team shall include at least:

- One (1) ACT team leader, who is a full time LMHP who must have both administrative and clinical skills;
- One (1) prescriber, who can be either a board-certified or board-eligible psychiatrist, or a medical psychologist, or an advanced practice registered nurse (APRN) with specialty in adult mental health and meeting the medical director requirements of licensure for Behavioral Health Service (BHS) providers;

  - In the event medical psychologist or APRN are utilized, the team must be able to consult with psychiatrists.

- Two (2) nurses, at least one (1) of whom shall be a RN. Both nurses must have experience in carrying out medical functioning activities such as basic health and medical assessment, education and coordination of health care, psychiatric medical assessment and treatment, and administration of psychotropic medication;
- One other LMHP;
- One substance use specialist, who has a minimum of one (1) year specialized substance use training or supervised experience;
- One employment specialist, who has at least one (1) year of specialized training or supervised experience;

Provider Qualifications and Responsibilities Continued

- One housing specialist, who has at least one (1) year of specialized training or supervised experience; and

- One peer specialist, who is self-identified as being in recovery from mental illness and/or substance use disorders, and who has successfully completed OBH required training and credentialing requirements as a peer specialist;

Staffing levels should increase proportional to the number of members served by the team in congruence with standards outlined within the DACTS.

Fidelity

Conduct ongoing monitoring and evaluation of program implementation through the collection of process and outcome measures. Process measures should be obtained through utilization of the EBP Fidelity Scale and General Organizational Index as found within the SAMHSA ACT Toolkit. Outcome measures such as homelessness, hospitalizations (psychiatric/medical), emergency department presentations (psychiatric/medical), incarcerations or arrests/detainments, substance use treatment (residential/inpatient), utilizations of primary care physician (PCP), employment and educational status should be collected in addition to the EBP fidelity measures.

Billing

NOTE: Individualized substance use treatment will be provided to those members for whom this is appropriate; co-occurring disorder treatment groups will also be provided off-site of the ACT administrative offices, though they do not take the place of individualized treatment.

The following activities may not be billed or considered the activity for which the ACT per diem is billed:

- Time spent doing, attending, or participating in recreational activities.
- Services provided to teach academic subjects or as a substitute for educational personnel. including, but not limited to, a teacher, teacher's aide or an academic tutor.
- Habilitative services for the adult to acquire, retain, and improve the self-help, socialization and adaptive skills necessary to reside successfully in community settings.
- Child care services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
- Respite care.
- Transportation for the individual or family. Services provided in the car are considered transportation.
- Services provided to members under age 18.
- Covered services that have not been rendered.
- Services provided before approved authorization.
- Services rendered that are not in accordance with an approved authorization.

Billing Continued

- Services not identified on the authorized treatment plan.
- Services provided without prior authorization.
- Services provided to the children, spouse, parents, or siblings of the eligible adult under treatment or others in the eligible member's life to address problems not directly related to the eligible member's issues and not listed on the eligible member's treatment plan.
- Services provided that are not within the provider's scope of practice.
- Any art, movement, dance or drama therapies.
- Anything not included in the approved ACT services description.


Please note this is not all inclusive information regarding ACT. For detailed information, please refer to the Behavioral Health Services Provider Manual.

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Functional Family Therapy (FFT) and Functional Family Therapy - Child Welfare (FFT-CW)

Functional Family Therapy (FFT) and Functional Family Therapy – Child Welfare (FFT-CW)

The provider agency must have a current certification issued by the Institute for FFT Inc. The licensed entity has agreed to assume responsibility for this service under its license. The provider contracts with FFT, Inc. for training, supervision and monitoring of services. This occurs primarily through a FFT national consultant. The provider will also have a contractual relationship with FFT Inc., allowing the provider to deliver the licensed FFT model.

FFT services are targeted for youth primarily demonstrating externalizing behaviors or at risk for developing more severe behaviors, which affect family functioning. Youth behaviors include antisocial behavior or acts, violent behaviors and other behavioral issues that impair functioning. Youth may also meet criteria for a disruptive behavior disorder (attention deficit/hyperactivity disorder (ADHD), oppositional defiant disorder and/or conduct disorder). Youth with other mental health conditions, such as anxiety and depression, may also be accepted as long as the existing mental and behavioral health (BH) issues manifest in outward behaviors that impact the family and multiple systems. Youth with substance use issues may be included if they meet the criteria below, and FFT is deemed clinically more appropriate than focused drug and alcohol treatment. However, acting out behaviors must be present to the degree that functioning is impaired and the following terms are met:

• Youth, ages 10-18, typically referred by other service providers and agencies on behalf of the youth and family, though other referral sources are also appropriate.

Functional Family Therapy (FFT) and Functional Family Therapy – Child Welfare (FFT-CW) Continued

- At least one adult caregiver is available to provide support and is willing to be involved in treatment.

- A DSM-5 diagnosis as primary focus of treatment. Symptoms and impairment must be the result of a primary disruptive/externalizing behavior disorder, although internalizing psychiatric conditions and substance use disorders may be secondary.

- Functional impairment not solely a result of an autism spectrum disorder or intellectual disability.

- Youth displays externalizing behavior that adversely affects family functioning. Youth's behaviors may also affect functioning in other systems.

- Documented medical necessity for an intensive in-home service.

FFT-CW services are targeted for youth and families with suspected or indicated child abuse or neglect. Problems include youth truancy, educational neglect, parental neglect or abuse, a history of domestic violence, adult caregiver substance use, and adult caregiver anxiety, depression and other mental health issues. Youth may also meet criteria for a disruptive behavior disorder (ADHD, oppositional defiant disorder and/or conduct disorder). Youth with other mental health conditions, such as anxiety and depression, may also be accepted as long as the existing mental and BH issues manifest in outward behaviors that impact the family and multiple systems. Youth with substance use issues may be included if they meet the criteria below, and FFTCW is deemed clinically more appropriate than focused drug and alcohol treatment.

Functional Family Therapy (FFT) and Functional Family Therapy – Child Welfare (FFT-CW) Continued

However, acting out behaviors must be present to the degree that functioning is impaired and the following terms are met:

• Families of youth, ages 0-18, typically referred by other service providers and agencies on behalf of the youth and family, though other referral sources are also appropriate.

• At least one adult caregiver is available to provide support and is willing to be involved in treatment.

• A DSM-5 diagnosis as primary focus of treatment. Symptoms and impairment must be the result of a primary disruptive/externalizing behavior disorder or internalizing psychiatric conditions and substance use. Diagnosis can be for youth or caregiver.

• Functional impairment not solely a result of an autism spectrum disorder or intellectual disability.

• Documented medical necessity for an intensive in-home service.

Functional Family Therapy (FFT) and Functional Family Therapy – Child Welfare (FFT-CW) Continued

FFT and FFTCW are deemed a best practice/family-based approach to providing treatment to youth who are between the ages of 10 and 18 (0 to 18 for FFT CW) and are exhibiting significant externalizing behaviors. It is a systems-based model of intervention/prevention, which incorporates various levels of the member's interpersonal experiences to include cognitive, emotional and behavioral experiences, as well as intrapersonal perspectives which focus on the family and other systems (within the environment) and impact the youth and his or her family system.

FFT/FFTCW is a strengths-based model of intervention, which emphasizes the capitalization of the resources of the youth, their family and those of the multi-system involved. Its purpose is to foster resilience and ultimately decrease incidents of disruptive behavior for the youth. More specifically, some of the goals of the service are to reduce intense/ negative behavioral patterns, improve family communication, parenting practices and problem-solving skill, and increase the family's ability to access community resources.

Provider Qualifications and Responsibilities

FFT/FFTCW agencies must be licensed pursuant to La. R.S. 40:2151, et. seq. for behavioral health service providers and certified by the Institute for FFT, LLC. The provider agency must meet all qualifications as required for other outpatient and rehabilitation agencies and must maintain documentation and verification of licensure, certification through the Institute for FFT, LLC, staff criminal background checks, TB testing, drug testing and required training for staff employed or contracted with the agency. FFT/FFTCW-only agencies are not required to be accredited due to the extensive nature of consultation by the Institute for FFT. These agencies must maintain good standing with the Institute for FFT, ensure fidelity to the FFT/FFTCW model and maintain licensure through LDH.

NOTE: Agencies providing non-EBP rehabilitation and/or addiction services in addition to FFT/FFTCW must be accredited by an LDH approved national accrediting body: CARF, COA or TJC.

Provider Qualifications and Responsibilities Continued

FFT/FFT-CW agencies must adhere to all requirements established in the Provider Responsibilities section located in the Outpatient Services: Rehabilitation Services chapter of the Behavioral Health Services Provider Manual.

Exceptions:

• BHSPs exclusively providing the evidence-based practice Functional Family Therapy (FFT/FFT-CW), Homebuilders® or Multi-Systemic Therapy (MST) are excluded from the requirement to provide medication management. Such BHSPs shall develop policies and procedures to ensure:

* Screening of clients for medication management needs;
* Referral to appropriate community providers for medication management including assistance to the client/family to secure services; and
* Collaboration with the client's medication management provider as needed for coordination of the client's care.

• BHSPs exclusively providing the evidence-based practice Functional Family Therapy (FFT/FFT-CW), Homebuilders® or Multi-Systemic Therapy (MST) are excluded from the requirement of having a Medical Director. Such BHSPs shall have a Clinical Director in accordance with core staffing requirements detailed in this manual chapter under Provider Responsibilities in Section 2.3 – Outpatient Services – Rehabilitation Services for Children, Adolescents, and Adults.

Fidelity

There are four domains of assessment used to monitor progress towards goals:

• Member assessment (through the use of the outcomes questionnaire (OQ) family measures pre-assessment, risk and protective factors assessments pre-assessment, relational assessment):

* Helps understand individual, family and behavior in a context functioning.
* Adds to clinical judgment, helps target behavior change targets, tool in treatment.

• Adherence assessment (through the use of the Family Self Report and Therapist Self Report, and Clinical Services System (CSS) tracking/adherence reports, global therapist ratings):

* Identify adherence to FFT/FFTCW to enhance learning and supervision.
* Judge clinical progress, monitor clinical decisions.

• Outcome assessment (through the use of therapist outcome measure, counseling outcome measure parent/adolescent and post assessment OQ family measures and post risk and protective factors assessment):

* To understand the outcome of your work – accountability.
* Changes in member functioning (pre-post).

NOTE: The term “counseling” throughout the FFT section is in keeping with the nomenclature of this evidenced based practice and should not be mistaken for the counseling and psychotherapy rendered by LMHPs under their respective scope of practice license.

• Case monitoring and tracking (member service system reports) Every member contact/planned contact, outcome of that contact (helps monitor practice)

Fidelity Continued

The provider will assess and monitor the delivery of the FFT/FFT-CW service via the use of the CSS. This is an online data base that has been originated by FFT, LLC. The type of data collected by the CSS includes:

- Assessments of risk and protective factors (Risk and Protective Factors Assessment)

- Relationship assessments (this is embedded in the progress note)

- Individual functioning (pre- and post-intervention) (OQ-45.2)

- Functioning within the context of the assessments (pre- and post-intervention) YOQ 2.01 and YOQ SR

- Assessments of family and therapist agreement (Family Self Report and Therapist Self Report)

Fidelity Ratings (Weekly adherence ratings – by national consultant in Year One and by site supervisor in Year Two and beyond)

- FFT/FFT-CW global therapist rating

- Tri-yearly Performance Evaluation, which provides Completion rates, Time of drop-out, Reasons for drop-out, Caseload information, Case tracking information, Fidelity and Adherence information, Assessment Completion information.

Each FFT/FFTCW therapist will receive a log on and password for the CSS for referencing their own members only. The provider will receive an administrator/evaluator log on and password. The FFT national consultant will also have access to the data from the CSS.

Billing

Only direct staff face-to-face time with the child or family may be billed. FFT/FFT-CW may be billed under CPST, but must be consistent with the CPST State Plan definition. CPST is a face-to-face intervention with the individual present; however, family or other collaterals may also be involved, and the child/youth receiving treatment does not need to be present for all contacts.

Collateral contacts billable to Medicaid should involve contacts with parents, guardians or other individuals having a primary care relationship with the individual receiving treatment. All contacts must be based on goals from the child's/youth's plan of care. Phone contacts are not billable.

NOTE: The exception to the allowance of collateral contacts while providing evidence-based practices is coordination with other child-serving systems such as parole and probation programs, public guardianship programs, special education programs, child welfare/child protective services and foster care programs. Coordination with these child-serving systems is considered collateral contact and may be necessary to meet their goals of the individual, but is not billable through Medicaid. Services may be provided by these child-serving systems, however, the services provided must be funded through the agency providing the service.

Billing Continued

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

• Medicaid may not reimburse for children in the custody of OJJ, who reside in detention facilities, public institutions or secure care and are inmates of a public institution. If the child is in OJJ custody, but not in a public correctional institution (i.e., is outpatient), Medicaid will reimburse for the FFT/FFT-CW, except for the oversight of restorative measures, which is an OJJ function.

• Medicaid will not reimburse for services provided to children who are residents of institutions for mental diseases (IMDs), which are institutions with greater than 16 beds, where more than 50 percent of the residents require treatment for BH conditions.

• Medicaid does not pay when the vocational supports provided via FFT qualify for vocational rehabilitation funding, even if the vocational rehabilitation services are not available.


Please note this is not all inclusive information regarding FFT/FFT-CW. For detailed information, please refer to the Behavioral Health Services Provider Manual.

Homebuilders

Homebuilders

The provider agency must be an approved Homebuilders provider for Louisiana. The licensed entity has agreed to assume responsibility for this service under its license. The provider contracts with Institute for Family Development (IFD) for training, supervision and monitoring of services. This occurs primarily through a Homebuilders® national consultant. IFD provides training and consultation to teams as part of a contract with the Department of Children and Family Services (DCFS). Teams are expected to maintain Homebuilders standards or they can be put on a quality improvement plan.

Homebuilders® is an intensive, in-home evidence based program (EBP) utilizing research based strategies (e.g. motivational interviewing, cognitive and behavioral interventions, relapse prevention, skills training), for families with children (birth to 18 years of age) at imminent risk of out of home placement (requires a person with placement authority to state that the child is at risk for out of home placement without Homebuilders®), or being reunified from placement.

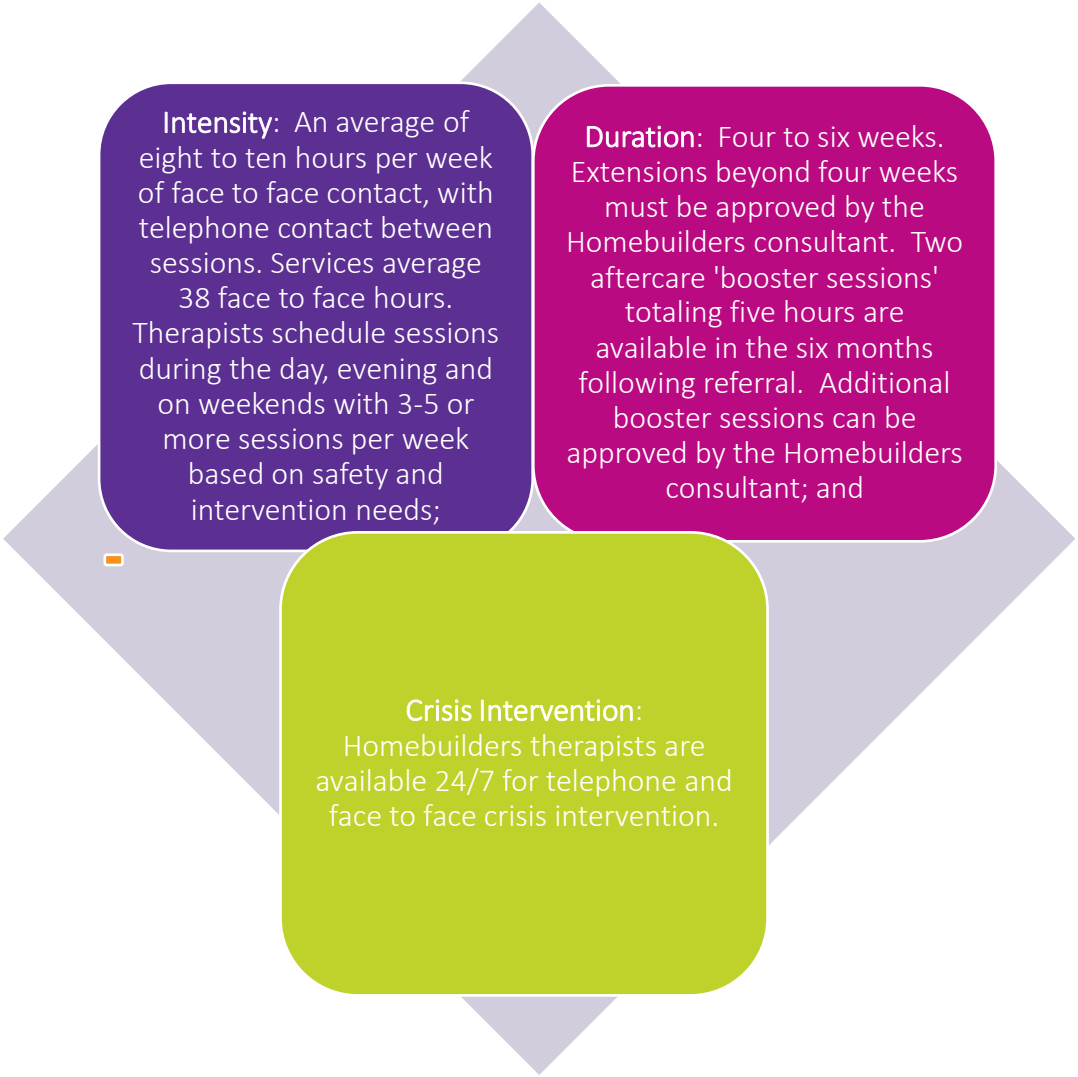
Homebuilders Continued

Homebuilders® is provided through IFD. Homebuilders® participants demonstrate the following characteristics:

- Children/youth with serious behavioral and/or emotional problems in the home, school, and/or community;
- Family members with substance abuse problems, mental health problems, poverty related concerns (lack of adequate housing, clothing and/or food);
- Babies that were born substance-exposed or considered failure to thrive;
- Teenagers/adolescents that run away from home, have suicidal risk, have attendance and/or behavioral problems at school, have drug and alcohol use, and/or experience parent-teen conflict(s); and/or
- Children/youth who have experienced abuse, neglect, or exposures to violence or other trauma.

Homebuilders Continued

Homebuilders® consists of:



Target Population

The goals of Homebuilders® are to reduce child abuse and neglect, family conflict, and child behavior problems, and improve parenting skills, family interactions, and family safety to prevent the imminent need for placement or successfully reunify children.

The Homebuilders® model is designed to eliminate barriers to service while using research-based interventions to improve parental skills, parental capabilities, family interactions, children's behavior, and well- being, family safety and the family environment.

The children are returning from, or at risk of, placement into foster care, group or residential treatment, psychiatric hospitals or juvenile justice facilities.

Homebuilders® is specifically aimed toward children and families identified with:

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

Provider Qualifications and Responsibilities

Homebuilders® agencies must be licensed pursuant to La. R.S. 40:2151, et. seq. for behavioral health service providers. The provider agency must meet all qualifications as required for other outpatient and rehabilitation agencies and must maintain documentation and verification of licensure, certification by IFD, staff criminal background checks, Tuberculosis (TB) testing, drug testing and required training for staff employed or contracted with the agency. Homebuilders® only agencies are not required to be accredited due to the extensive nature of consultation by IFD. These agencies must maintain good standing with IFD, ensure fidelity to the Homebuilders® model and maintain licensure through the Louisiana Department of Health (LDH).

NOTE: Agencies providing non-EBP rehabilitation and/or addiction services in addition to Homebuilders® must be accredited by an LDH approved national accrediting body: CARF, COA or TJC.

Provider Qualifications and Responsibilities Continued

Homebuilders® agencies must adhere to all requirements established in the Provider Responsibilities section located in the Outpatient Services: Rehabilitation Services chapter of the Behavioral Health Services Provider Manual.

Exceptions:

• BHSPs exclusively providing the evidence-based practice Functional Family Therapy (FFT/FFTCW), Homebuilders® or Multi-Systemic Therapy (MST) are excluded from the requirement to provide medication management. Such BHSPs shall develop policies and procedures to ensure:

* Screening of clients for medication management needs;
* Referral to appropriate community providers for medication management including assistance to the client/family to secure services; and
* Collaboration with the client's medication management provider as needed for coordination of the client's care.

• BHSPs exclusively providing the evidence-based practice Functional Family Therapy (FFT/FFTCW), Homebuilders® or Multi-Systemic Therapy (MST) are excluded from the requirement of having a Medical Director. Such BHSPs shall have a Clinical Director in accordance with core staffing requirements detailed in this manual chapter under Provider Responsibilities in Section 2.3 – Outpatient Services – Rehabilitation Services for Children, Adolescents, and Adults.

Fidelity

All programs are required to use the web-based member documentation and data system (ODM). All member documentation is entered (with guidelines about when this occurs) into ODM, and data reports are generated from the information that go into part of the fidelity and site reviews.

Site Reviews

There are two onsite visits a year:

* A mid-year review (go out on home visits, observe team consultation, meet with administrators, etc.), with only quantitative data run and reported; and

* A year-end full-site review (visit with home visits, team consultation reviews, file reviews, etc.) – After full site reports are completed, Professional Development Plans (PDPs) and Quality Enhancement Plans (QE plans) are developed after.

IFD supports the creation of PDPs for individuals and QE plans for the team. When/if serious problems occur Quality Improvement plans (QI plans) are developed and are time limited, and can result in individual or teams not being allowed to deliver Homebuilders®. Please see the website for more information: www.institutefamily.org

Fidelity Continued

Exclusions

Homebuilders® services are comprehensive of all other services, with the exception of psychological evaluation or assessment and medication management. These may be provided and billed separately for a recipient receiving Homebuilders® services.

Homebuilders® shall **not** be billed in conjunction with the following services:

*Behavioral health (BH) services by licensed and unlicensed individuals, other than medication management and assessment; and

* Residential services, including professional resource family care.

Billing

• Only direct staff face-to-face time with the child or family may be billed. Homebuilders® may be billed for under community psychiatric supportive treatment (CPST), but must be consistent with the CPST State Plan definition. CPST is a face-to-face intervention with the individual present; however, family or other collaterals may also be involved, and the child/youth receiving treatment does not need to be present for all contacts.

• Collateral contacts billable to Medicaid should involve contacts with parents, guardians or other individuals having a primary care relationship with the individual receiving treatment. All contacts must be based on goals from the child's/youth's plan of care. Phone contacts are not billable.

NOTE: The exception to the allowance of collateral contacts while providing evidence-based practices is coordination with other child-serving systems such as parole and probation programs, public guardianship programs, special education programs, child welfare/child protective services and foster care programs. Coordination with these child-serving systems is considered collateral contact and may be necessary to meet their goals of the individual but is not billable through Medicaid. Services may be provided by these child-serving systems, however, the services provided must be funded through the agency providing the service. • Time spent in travel, transporting children, documenting, supervision, training, etc. has been factored into the indirect unit cost and may not be billed directly.

Homebuilders® shall not be billed in conjunction with the following services:

• Behavioral health (BH) services by licensed and unlicensed individuals, other than medication management and assessment; and
• Residential services, including professional resource family care.

Billing Continued

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

• Medicaid funding may not reimburse for children in the custody of the Office of Juvenile Justice (OJJ), who reside in detention facilities, public institutions or secure care and are inmates of a public institution. If the child is in OJJ custody, but not in a public correctional institution (i.e., is outpatient), Medicaid will reimburse for the Homebuilders® except for the oversight of restorative measures, which is an OJJ function.

• Medicaid will not reimburse for services provided to children who are residents of IMDs, which are institutions with greater than 16 beds, where more than 50 percent of the residents require treatment for BH conditions.

• Medicaid does not pay when the vocational supports provided via Homebuilders® qualify for vocational rehabilitation funding, even if the vocational rehabilitation services are not available.


Please note this is not all inclusive information regarding Homebuilders® . For detailed information, please refer to the Behavioral Health Services Provider Manual.

Child Parent Psychotherapy (CPP)

Child Parent Psychotherapy

Child Parent Psychotherapy (CPP) is an intervention for children age 0-6 and their parents who have experienced at least one form of trauma including but not limited to maltreatment, sudden traumatic death of someone close, a serious accident, sexual abuse, or exposure to domestic violence. The primary goal of the treatment is to support and strengthen the relationship between a child and his or her parent (or caregiver) in order to repair the child's sense of safety, attachment, and appropriate affect to ultimately improve the child's cognitive, behavioral, and social functioning.

Child Parent Psychotherapy is a model used within the service Outpatient Therapy by Licensed Practitioners, so follows the requirements set out in the “Outpatient Therapy by Licensed Practitioners” section of the Behavioral Health Services Provider Manual.

Target Population

Children: Birth–6 years old that have:

* Experienced at least one traumatic event and
* Are experiencing behavior, attachment, and/or mental health problems, including posttraumatic stress disorder (PTSD) because of experienced trauma.
* And Parent(s)/Caretaker(s) of traumatized child.

CPP may help when:

* Children have been through scary or painful events such as
* loss of a loved person;
* separation;
* serious medical procedures;
* abuse or violence at home or in the community;
* Children show difficult behaviors;
* Children have a change in placement or caregivers;
* Family members have physical health or mental health difficulties; or
* Caregivers would like help with parenting and improving parent-child relationships.

Provider Qualifications and Responsibilities

EBP Model Requirements

Therapists must achieve satisfactory completion of the full eighteen (18) month CPP training, upon which the clinician will be eligible to join the roster of nationally trained CPP therapists. This list is held by the Child Parent Psychotherapy Learning Collaborative in Louisiana. Providers must submit verification of inclusion on the roster of nationally trained CPP therapists to each MCO with whom it contracts to demonstrate eligibility for CPP therapist status. Verification must be maintained in the therapist's personnel folder.

All clinicians seeking to complete training and be eligible for the CPP roster must be masters or doctoral-level licensed psychotherapists with a degree in a mental health discipline.

Certification should be maintained by engaging in periodic fidelity review activities, including completion of a CPP Case Presentation (template) and case consultation calls with a CPP Trainer, at the frequency described below in the description of fidelity monitoring.

Other Qualifications and Requirements

Practitioners must meet qualifications and requirements established in the "Outpatient Therapy by Licensed Practitioners" section of the Behavioral Health Services Provider Manual.

Fidelity

Therapist fidelity to the CPP model is monitored via therapist submission of a Case Consultation form for one case, at two different time points during the case (early in treatment, as well as 2-3 months into treatment).

These Case Consultation forms are submitted to the CPP Trainer, who will review and follow up with the therapist on a 30-60 minute case consultation phone call.

To maintain CPP fidelity, CPP therapists should submit Case Consultation forms and complete a case consultation call with a CPP trainer at the following frequency:

* For the first 2 years post-certification: Every 6 months.
* Beyond 2 years post-certification: Annually.

Limitations/Exclusions

CPP, as a service offered under Outpatient Therapy by Licensed Practitioners, has an initial authorization level of benefit, and services which exceed the limitation of the initial authorization may require approval for re-authorization prior to service delivery. The recommended duration of the CPP model is 52 weeks; therefore re-authorization should be requested indicating that the specialty model CPP is being utilized and therefore appropriately may exceed the initial authorization and should be authorized for continuing services to complete the medically necessary treatment episode and provide evidence-based care to the youth and family.

Billing

• Only direct staff face-to-face time with the child or family may be billed. CPP is a face-to-face intervention with the individual and caregiver present; however, the child receiving treatment does not need to be present for all contacts. If the child is not present, the appropriate procedure code must be billed, e.g. 90846 - Family Psychotherapy without Patient Present.

• Collateral contacts billable to Medicaid should involve contacts with parents, guardians using the appropriate procedure code as stated above. All contacts must be based on goals from the child's/youth's plan of care. Phone contacts are not billable.

NOTE: The exception to the allowance of collateral contacts while providing evidence-based practices is coordination with other child-serving systems such as parole and probation programs, public guardianship programs, special education programs, child welfare/child protective services and foster care programs. Coordination with these child-serving systems is considered collateral contact and may be necessary to meet their goals of the individual, but is not billable through Medicaid. Services may be provided by these child-serving systems, however, the services provided must be funded through the agency providing the service.

Billing Continued

• Therapists bill standard CPT individual and family therapy codes for sessions providing CPP. The EBP tracking code "EBP02" should be indicated on claims to note that the therapy session utilized CPP as an evidence-based model of therapeutic intervention.

• To use the CPP EBP tracking code of "EBP02" on claims, the therapist must first provide documentation (stating that the clinician has fulfilled the requirements of an implementation level course in Child-Parent Psychotherapy from a trainer endorsed by the University of California, San Francisco) to the MCO(s) the provider is contracted with as part of the therapist's credentialing.


Please note this is not all inclusive information regarding CPP. For detailed information, please refer to the Behavioral Health Services Provider Manual.

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Parent Child Interaction Therapy (PCIT)

Parent Child interaction Therapy

Parent-child interaction therapy (PCIT) is an evidence-based behavior parent training treatment developed by Sheila Eyberg, PhD for young children with emotional and behavioral disorders that places emphasis on improving the quality of the parent-child relationship and changing parent child interaction patterns. Children and their caregivers are seen together in PCIT. Parents are taught and practice communication skills and behavior management with their children in a playroom while coached by therapists. The activities and coaching by a therapist enhance the relationship between parent and child and help parents implement non-coercive discipline strategies.

PCIT is a model used within the service Outpatient Therapy by Licensed Practitioners, so follows the requirements set out in the “Outpatient Therapy by Licensed Practitioners” section of the Behavioral Health Services Provider Manual.

Target Population

PCIT serves children ages 2-7 years old (can be up to 9 based on clinical judgement) with:

* Disruptive behavior problems
* ADHD
* Selective mutism or
* Anxiety

PCIT may not be clinically appropriate for individuals with significant social reciprocity deficits.

PCIT effectively serves children whose parents:

* have limited experience with children;
* have limited support;
* feel overwhelmed by their child's behavior;
* feel angry at their child;
* have a child with an opposing temperament from their own; or
* feel their child is out of control.

Provider Qualifications and Responsibilities

EBP Model Requirements

The provider must be credentialed by PCIT International and have an active PCIT certification. PCIT certification must be renewed every two years through PCIT International. The recertification requires the therapist to have obtained at least 3 hours of PCIT Continuing Education credit the last 2 years through educational activities sponsored by the PCIT International Task Force on Continuing Education.

Providers must submit verification of active PCIT certification to each MCO with whom it contracts to demonstrate eligibility for PCIT therapist status. Verification must be maintained in the therapist's personnel folder.

Other Qualifications and Requirements

Practitioners must meet qualifications and requirements established in the "Outpatient Therapy by Licensed Practitioners" section of the Behavioral Health Services Provider Manual.

Fidelity

In order to reach the standard to be a Certified PCIT Therapist (as per PCIT International) the therapist must serve as a therapist for a minimum of two PCIT cases to graduation criteria as defined by the 2011 PCIT Protocol. Until the two PCIT cases meet graduation criteria, the applicant must remain in contact via real-time consultation (e.g., telephone conference or live, online, or telehealth observation) or video review with feedback with a certified PCIT Trainer at least twice a month. The PCIT protocol (which the therapist receives consultation on throughout the course of the case) includes therapist completion of a fidelity checklist at each session, and review of fidelity during supervision.

Fidelity is then directly assessed via the following requirement: Applicants must have their treatment sessions observed by a certified PCIT Trainer. Observations may be conducted in real time (e.g., live or online/telehealth) or through video recording. PCIT therapist certification requirements can be found here: http://www.pcit.org/uploads/6/3/6/1/63612365/therapist_training_guidelines_revised_1.25.18_fi nal.pdf

PCIT does not require post-certification fidelity monitoring. PCIT does require re-certification every 2 years, with evidence of PCIT Continuing Education hours.

Limitations/Exclusions

PCIT, as a service offered under Outpatient Therapy by Licensed Practitioners, has an initial authorization level of benefit, and services which exceed the limitation of the initial authorization may require approval for re-authorization prior to service delivery.

Fidelity Continued

As per the PCIT model, families graduate from treatment when parents demonstrate mastery of skills and rate their child's behaviors as being within normal limits. PCIT sessions continue through completion of the “child directed interaction” component, and the “parent directed interaction” component, both of which are completed when a parent meets specific criteria defined as “mastery” of the skills. While a typical course of treatment averages 15-20 sessions, PCIT is not session-limited but instead the model duration depends on clinical outcome. Therefore, effective treatment duration may exceed the initial authorization level of benefit; in that case re-authorization should be requested indicating that the specialty model PCIT is being utilized and services appropriately may exceed the initial authorization and should be authorized for continuing services to complete the medically necessary treatment episode and provide evidence-based care to the youth and family.

Billing

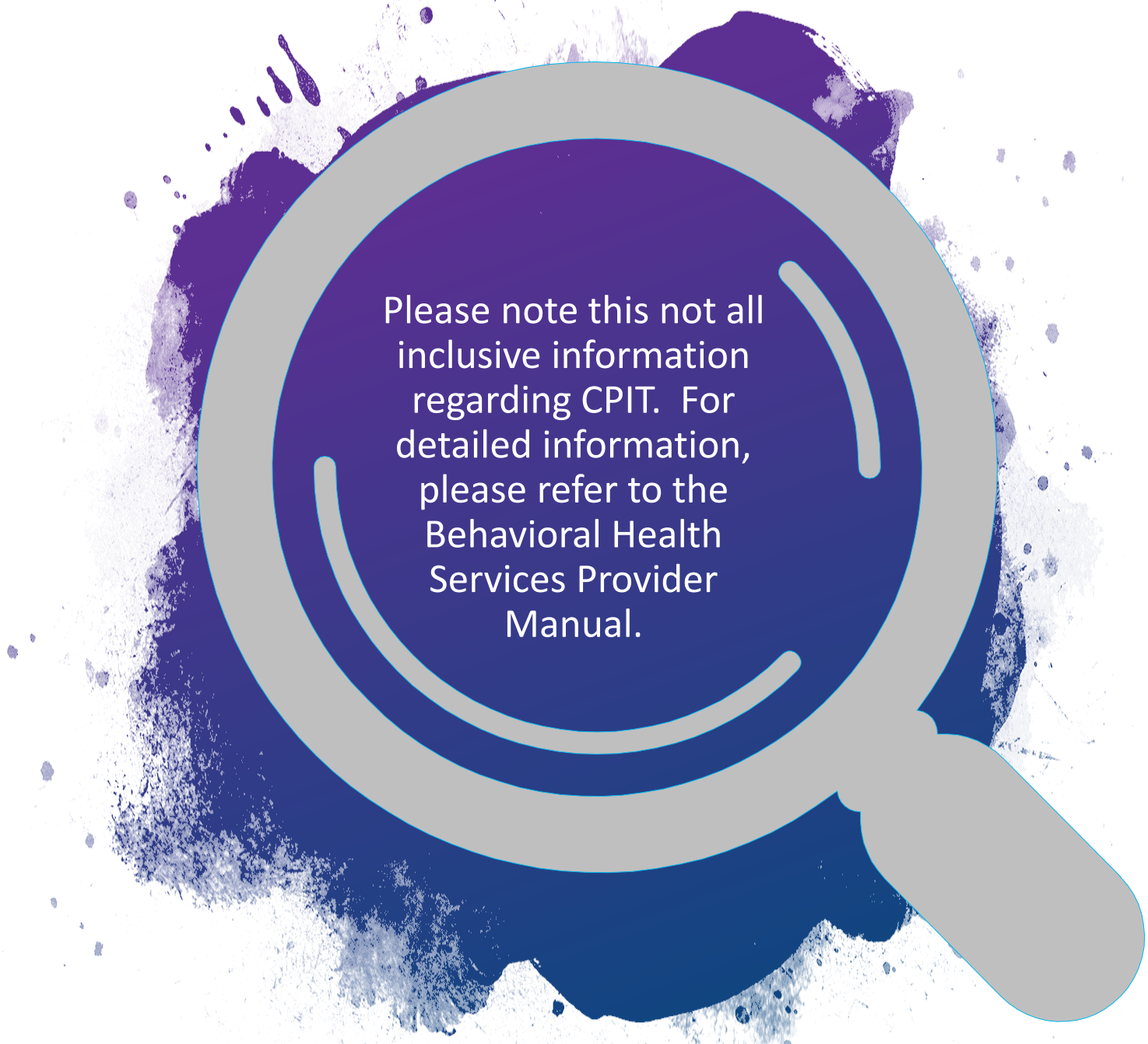
• Only direct staff face-to-face time with the child or family may be billed. PCIT is a face-to-face intervention with the individual and caregiver present; however, the child receiving treatment does not need to be present for all contacts. If the child is not present, the appropriate procedure code must be billed, e.g. 90846 - Family Psychotherapy without Patient Present.

• Collateral contacts billable to Medicaid should involve contacts with parents, guardians using the appropriate procedure code as stated above. All contacts must be based on goals from the child's/youth's plan of care. Phone contacts are not billable.

NOTE: The exception to the allowance of collateral contacts while providing evidence-based practices is coordination with other child-serving systems such as parole and probation programs, public guardianship programs, special education programs, child welfare/child protective services and foster care programs. Coordination with these child-serving systems is considered collateral contact and may be necessary to meet their goals of the individual, but is not billable through Medicaid. Services may be provided by these child-serving systems, however, the services provided must be funded through the agency providing the service.

• Therapists bill standard CPT individual and family therapy codes for sessions providing PCIT. The EBP tracking code "EBP03" should be indicated on claims to note that the therapy session utilized PCIT as an evidence-based model of therapeutic intervention.

  o To use the PCIT EBP tracking code of "EBP03" on claims, the therapist must first provide documentation of their active certification from PCIT International to the MCO(s) the provider is contracted with, as part of the therapist's credentialing.


Please note this not all inclusive information regarding CPIT. For detailed information, please refer to the Behavioral Health Services Provider Manual.

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Preschool PTSD Treatment (PPT) and Youth PTSD Treatment (YPT)

Preschool PTSD Treatment (PPT) and Youth PTSD Treatment (YPT)

Preschool PTSD Treatment (PPT) and Youth PTSD Treatment (YPT) are cognitive behavioral therapy interventions for posttraumatic stress disorder (PTSD) and trauma-related symptoms. PPT and YPT are adapted for different age groups:

* Preschool PTSD Treatment (PPT) is used for children ages 3-6.
* Youth PTSD Treatment (YPT) is used for children and youth ages 7-18.

PPT and YPT are models used within the service Outpatient Therapy by Licensed Practitioners, so follows the requirements set out in the "Outpatient Therapy by Licensed Practitioners" section of the Behavioral Health Services Provider Manual.

Target Population

PPT: Children ages 3-6 years old with posttraumatic stress symptoms.

YPT: Children and youth ages 7-18 years old with posttraumatic stress symptoms.

Provider Qualifications and Responsibilities

EBP Model Requirements

Therapists must receive training and consultation, as outlined below under "Training," to receive "Advanced" certification in PPT or YPT from Tulane Psychiatry. All clinicians seeking to complete training and to be eligible for advanced certification in PPT or YPT must be masters or doctor-level licensed psychotherapists with a degree in a mental health discipline.

Providers must submit verification of "Advanced" certification in PPT or YPT from Tulane Psychiatry to each MCO with whom it contracts to demonstrate eligibility for PPT or YPT therapist status. Verification must be maintained in the therapist's personnel folder.

Other Qualifications and Requirements

Practitioners must meet qualifications and requirements established in the Outpatient Therapy by Licensed Practitioners section of the Behavioral Health Services Provider Manual.

Fidelity

Fidelity monitoring can be achieved by auditing the “Treatment Fidelity Progress Notes.” The audit would produce a passing score if 90% of the core tasks were partially or fully completed.

The EBP developer recommends that every 6 months, a sample of completed cases should be identified, and the PPT or YPT therapist will submit for each selected (completed) case the full set of “Treatment Fidelity Progress Notes” for that case.

Limitations/Exclusions

PPT and YPT are not recommended for children and youth with autism or psychosis. As previously noted, PPT and YPT have not been adapted or tested for use with non-English speaking children and families.

PPT and YPT, as a service offered under Outpatient Therapy by Licensed Practitioners, has an initial authorization level of benefit, and services which exceed the limitation of the initial authorization may require approval for re-authorization prior to service delivery.

The recommended duration of the PPT and YPT models is 12 sessions. If additional sessions are needed to complete PPT or YPT, re-authorization should be requested indicating that the specialty model PPT or YPT are being utilized and therefore appropriately may exceed the initial authorization and should be authorized for continuing services to complete the medically necessary treatment episode and provide evidence-based care to the youth and family.

Billing

• Only direct staff face-to-face time with the child or family may be billed. PPT and YPT are face-to-face interventions with the individual present; however, the caregiver is also involved, and the child/youth receiving treatment does not need to be present for all contacts. If the child is not present, the appropriate procedure code must be billed, e.g. 90846 – Family Psychotherapy without Patient Present.

• Collateral contacts billable to Medicaid should involve contacts with parents, guardians using the appropriate procedure code as stated above. All contacts must be based on goals from the child's/youth's plan of care. Phone contacts are not billable.

NOTE: The exception to the allowance of collateral contacts while providing evidence-based practices is coordination with other child-serving systems such as parole and probation programs, public guardianship programs, special education programs, child welfare/child protective services and foster care programs. Coordination with these child-serving systems is considered collateral contact and may be necessary to meet their goals of the individual, but is not billable through Medicaid. Services may be provided by these child-serving systems, however, the services provided must be funded through the agency providing the service.

Billing Continued

• Therapists bill standard CPT individual and family therapy codes for sessions providing PPT and YPT.

• The EBP tracking code “EBP04” should be indicated on claims to note that the therapy session utilized YPT as an evidence-based model of therapeutic intervention.

• To use the YPT EBP tracking code of “EBP04” on claims, the therapist must first provide documentation of their Advanced Certification from Tulane Psychiatry to the MCO(s) the provider is contracted with, as part of the therapist’s credentialing package.

• The EBP tracking code “EBP05” should be indicated on claims to note that the therapy session utilized PPT as an evidence-based model of therapeutic intervention.

• To use the PPT EBP tracking code of “EBP05” on claims, the therapist must first provide documentation of their Advanced Certification from Tulane Psychiatry to the MCO(s) the provider is contracted with, as part of the therapist’s credentialing package.


Please note this is not all inclusive information regarding PPT/YPT. For detailed information, please refer to the Behavioral Health Services Provider Manual.

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Triple P-Standard Level 4

Triple P-Standard Level 4

The Triple P Positive Parenting Program is a parenting and family support system designed to prevent and treat behavioral and emotional problems in children. It aims to prevent problems in the family, school and community before they arise and to create family environments that encourage children to realize their potential. The “Triple P System” includes a suite of interventions with different intensity levels and delivery methods, to meet the individual needs of youth and parents.

Triple P – Standard Level 4 is designed to be delivered to the parents of children with moderate to severe behavioral difficulties. It is available for parents of children from birth to 12 years old and covers Triple P's 17 core positive parenting skills that can be adapted to a wide range of parenting situations.

Triple P – Standard Level 4 is a model used within the service “Outpatient Therapy by Licensed Practitioners.” Therefore, it follows the requirements set out in the “Outpatient Therapy by Licensed Practitioners” section of the Behavioral Health Services Provider Manual.

Target Population

The target population includes children ages 0-12 with their parents/primary caregivers.

The program is used as an intervention with the parents of children with:

* social,
* emotional, or
* behavioral problems.

Triple P Standard Level 4 is recommended for children with diagnosed social, emotional, or behavioral concerns.

Provider Qualifications and Responsibilities

EBP Model Requirements

To provide Triple P Standard Level 4 under Louisiana Medicaid, the provider must show accreditation by Triple P America (TPA). Triple P America (the dissemination body for Triple P in the US) holds the training and accreditation process for Triple P in the US. Only TPA is allowed to provide training and accreditation for Triple P in the US. Once a practitioner is accredited in Triple P, the accreditation does not expire and there are no further certification requirements.

Other Qualifications and Requirements

Practitioners must meet qualifications and requirements established in the “Outpatient Therapy by Licensed Practitioners” section of the Behavioral Health Services Provider Manual.

Fidelity

Fidelity to the Triple P model may be monitored as needed via document review of practitioner- completed Session Checklists. While practitioners should aim to complete 100% of the items on each Session Checklist, a completion rate of 80% of checklist items per session demonstrates acceptable fidelity to the model.

Limitations/Exclusions

Limitations and exclusions noted in the “Outpatient Therapy by Licensed Practitioners” apply.

Billing

- Only direct staff face-to-face time with the child or family may be billed. Triple P-Standard Level 4 is a face-to-face intervention delivered to the parent/primary caregiver and child dyad, for the benefit of the identified child. When the intervention is provided with both the caregiver(s) and child present, procedure codes for Individual Therapy or Family Therapy with Patient Present may be billed. If the child is not present during a parent-directed intervention component, the appropriate procedure code must be billed, e.g. Family Psychotherapy without Patient Present.

- Collateral contacts billable to Medicaid should involve contacts with parents, guardians using the appropriate procedure code as stated above. All contacts must be based on goals from the child's/youth's treatment plan or plan of care. Phone contacts are not billable.

NOTE: The exception to the allowance of collateral contacts while providing evidence-based practices is coordination with other child-serving systems such as parole and probation programs, public guardianship programs, special education programs, child welfare/child protective services and foster care programs. Coordination with these child-serving systems is considered collateral contact and may be necessary to meet their goals of the individual, but is not billable through Medicaid. Services may be provided by these child-serving systems, however, the services provided must be funded through the agency providing the service.

Billing Continued

- Therapists bill standard CPT individual and family therapy codes for sessions providing Triple P- Standard Level 4.

- The EBP tracking code “EB06” should be indicated on claims to note that the therapy session utilized Triple P-Level 4 as an evidence-based model of therapeutic intervention.

- To use the Triple P-Level 4 tracking code of “EB06” on claims, the therapist must first provide documentation of their accreditation in Triple P- Standard Level 4 (as issued by Triple P America) as part of the therapist’s credentialing package.


Please note this is not all inclusive information regarding Triple P-Standard Level 4. For detailed information, please refer to the Behavioral Health Services Provider Manual.

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Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a conjoint child and parent psychotherapy model for children who are experiencing significant emotional and behavioral difficulties related to traumatic life events. It is a components-based hybrid treatment model that incorporates trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles.

TF-CBT is a model used within the service “Outpatient Therapy by Licensed Practitioners,” so it follows the requirements set out in the “Outpatient Therapy by Licensed Practitioners” section of the Behavioral Health Services Provider Manual.

Target Population

TF–CBT was created for young people who have developed significant emotional or behavioral difficulties following exposure to a traumatic event (e.g., loss of a loved one, physical abuse, sexual abuse, domestic or community violence, motor vehicle accidents, fires, tornadoes, hurricanes, industrial accidents, terrorist attacks).

TF-CBT may benefit children with a known trauma history who are experiencing significant posttraumatic stress disorder (PTSD) symptoms, whether or not they meet full diagnostic criteria. In addition, TF-CBT may benefit children with depression, anxiety, and/or shame related to their traumatic exposure. Children experiencing childhood traumatic grief can also benefit from the treatment.

TF-CBT may be delivered to children ages 3-18 and their parents.

TF-CBT may not be appropriate for:

* Acutely suicidal youths;
* Adolescents with current parasuicidal behaviors (self-cutting or non-fatal self-harm);
* Youth with extensive inappropriate/illicit substance use;
* Youth with a history of significant behavioral problems present prior to the trauma exposure; or
* Youth with significant conduct problems (aggressive, destructive).

Provider Qualifications and Responsibilities

EBP Model Requirements

Practitioners must meet qualifications and requirements established in the Outpatient Therapy by Licensed Practitioners section of the Behavioral Health Services Provider Manual and requires training in the treatment model as minimum requirements.

Fidelity

Fidelity to the TF-CBT model may be reviewed as needed by reviewing treatment records. Records should demonstrate that: the TF-CBT provider used the TF-CBT Brief Practice Checklist to specify which components were used in each session; the therapist detailed in progress notes how those components were implemented in each session; and over the course of a completed case that the therapist used the majority of the PPRACTICE components to treat the child or youth.

The TF-CBT National Certification Program does not require post-certification fidelity monitoring. The TF-CBT National Certification Program does require therapists to re-certify every 5 years, by providing evidence of completion of 3 modules of re-certification education.

Limitations/Exclusions

Limitations and exclusions noted in the “Outpatient Therapy by Licensed Practitioners” apply.

Billing

- Only direct staff face-to-face time with the child or family may be billed. TF-CBT is a face-to-face intervention with the individual and caregiver present; however, the child receiving treatment does not need to be present for all contacts.

- Typical sessions during which there is both a child-delivered portion of the session, and a parent-delivered portion of the session, may be billed as 90832, 90834, or 90837 (or their successors) – Psychotherapy, with patient present, as long as:

    - The client is present for all or the majority (greater than 50%) of the time billed; and
    - The entirety of the service is provided to, or directed exclusively toward the treatment of, the Medicaid-eligible child or youth.

- If there is a parent-directed session for which the child is not present for the majority of the time, the appropriate procedure code must be billed, e.g. 90846 (or its successor)– Family Psychotherapy without Patient Present.

- The parent-directed session must be directed exclusively toward the treatment of the Medicaid-eligible child or youth.

Billing Continued

Collateral contacts billable to Medicaid should involve contacts with parents or guardians using the appropriate procedure code as stated above. All contacts must be based on goals from the child's/youth's plan of care. Phone contacts are not billable.

NOTE: The exception to the allowance of collateral contacts while providing evidence-based practices is coordination with other child-serving systems such as parole and probation programs, public guardianship programs, special education programs, child welfare/child protective services and foster care programs. Coordination with these child-serving systems is considered collateral contact and may be necessary to meet their goals of the individual, but is not billable through Medicaid. Services may be provided by these child-serving systems; however, the services provided must be funded through the agency providing the service.

- Therapists bill standard CPT individual and family therapy codes for sessions providing TF-CBT.

- The EBP tracking code "EB07" should be indicated on claims to note that the therapy session utilized TF-CBT as an evidence-based model of therapeutic intervention.

- To use the TF-CBT tracking code of "EB07" on claims, the therapist must first provide documentation of national certification in TF-CBT, as part of the therapist's credentialing package. Certified TF-CBT therapists are listed on a national registry at https://tfcbt.org/members/.

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Please note this not all inclusive information regarding TF-CBT. For detailed information, please refer to the Behavioral Health Services Provider Manual.

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Eye Movement Desensitization & Reprocessing Therapy (EMDR)

Eye Movement Desensitization & Reprocessing Therapy (EMDR)

Eye Movement Desensitization and Reprocessing (EMDR) Therapy is an evidence-based psychotherapy that treats trauma-related symptoms.

EMDR therapy is designed to resolve unprocessed traumatic memories in the brain. The therapist guides the client to process the trauma by attending to emotionally disturbing material in brief, sequential doses, while at the same time focusing on an external stimulus. The most commonly used external stimulus in EMDR therapy is alternating eye movements; however, sounds or taps may be used as well.

EMDR therapy is a model used within the service Outpatient Therapy by Licensed Practitioners, so follows the requirements set out in the “Outpatient Therapy by Licensed Practitioners” section of the Behavioral Health Services Provider Manual.

Target Population

Children, adolescents and adults. EMDR therapy may be used with children as young as two years of age, through adolescence and adulthood.

Scientific research has established EMDR therapy as clearly effective for post-traumatic stress and trauma-related symptoms. Trauma may result from a single event, multiple events or a series of events chronic in nature.

Clinician have also reported success using EMDR therapy in treatment of the following conditions:

* Anxiety, panic attacks, and phobias
* Chronic Illness and medical issues
* Depression and bipolar disorders
* Dissociative disorders
* Eating disorders
* Grief and loss
* Pain
* Performance anxiety
* Personality disorders
* Sleep disturbance
* Substance abuse and addiction

Provider Qualifications and Responsibilities

EBP Model Requirements

EMDRIA (EMDR International Association) sets the standards and requirements for EMDR therapy training. EMDRIA certifies individual clinical practitioners in the practice of EMDR therapy by ensuring all basic requirements, initial training, and ongoing certification are met (see www.emdria.org).

EMDRIA establishes two levels of training for practitioners in EMDR therapy. For the purposes of providing EMDR therapy under Louisiana Medicaid, either level (EMDRIA Approved Basic Training, or EMDR Certification) are acceptable qualifications.

The standard level of training, which allows a practitioner to provide EMDR therapy, is referred to as "EMDRIA Approved Basic Training."

Following completion of EMDR Basic Training, a practitioner may go on to achieve a more advanced level of training, referred to as "EMDR Certification." Once Certified in EMDR therapy, practitioners must re-certify every 2 years.

Other Qualifications and Requirements

Practitioners must meet qualifications and requirements established in the Outpatient Therapy by Licensed Practitioners section of the Behavioral Health Services Provider Manual.

Fidelity

During an EMDRIA Approved Basic Training course, therapist fidelity to the model is supported and monitored during Supervised Practicum (20 hours) and Consultation (10 hours).

If therapists go on to achieve EMDR Certification, their fidelity to the model is supported and monitored during an additional 20 hours of consultation.

EMDRIA does not require fidelity monitoring post-training or certification. However, Certified EMDR therapists receive additional support for EMDR fidelity by completing 12 hours of EMDR-specific continuing education in order to re-certify every 2 years.

Limitations/Exclusions

Limitations and exclusions noted in the “Outpatient Therapy by Licensed Practitioners” apply.

Billing

- Only direct staff face-to-face time with the individual or family may be billed. EMDR therapy is a face-to-face intervention with the individual present.
- Therapists bill standard CPT therapy codes for sessions providing EMDR therapy.
- The EBP tracking code “EB08” should be indicated on claims to note that the therapy session utilized EMDR as an evidence-based model of therapeutic intervention.
- To use the EMDR tracking code of “EB08” on claims, the therapist must first provide documentation of completion of EMDRIA Approved Basic Training, as part of the therapist’s credentialing package.


Please note this is not all inclusive information regarding EMDR Therapy. For detailed information, please refer to the Behavioral Health Services Provider Manual.

Tips and Resources

Tips for Writing Progress Notes
https://www.magellanoflouisiana.com/for-providers/provider-toolkit/provider-resources/tips-for-writing-progress-notes/

Tips for Treatment Plan Development
https://www.magellanoflouisiana.com/for-providers/provider-toolkit/provider-resources/tips-for-treatment-plan-development/

Behavioral Health Services Provider Manual
https://www.lamedicaid.com/provweb1/Providermanuals/manuals/BHS/BHS.pdf

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