

MENTAL HEALTH EXPENSES

The following must be included in order to file a claim for mental health counseling payment(s) or reimbursement:

- 1. Claim Form for Mental Health Expenses.**
- 2. Invoice from the mental health provider listing dates of services, mental health codes, and cost per session.**
- 3. Mental Health Initial Treatment Plan or Mental Health Treatment Update (if one is due).**
- 4. Mental health treatment must be for issues related to the victimization.**
- 5. Provider must be licensed in the State of Louisiana.**
- 6. See Mental Health Treatment Provider Information for additional Information.**

Louisiana Crime Victims Reparations Board
MENTAL HEALTH TREATMENT

Provider Information

Compensation of mental health expenses are subject to timely and accurate filing of required documents. Delays in filing may result in delays in compensation.

Treatment Plans & Reviews:

- a) **Mental Health Treatment Initial Plan** – This form must be completed by each therapist and submitted to either the crime investigator at the Sheriff’s office of jurisdiction, or the Louisiana Crime Victim’s Reparations Board (CVRB). This form should be submitted within 3 months of treatment onset and should indicate the relationship between the victim’s symptoms and treatment, and the experience of the reported crime.
- b) **Mental Health Treatment Update** – This form must be completed by each therapist and submitted every 6 months during the life of the case. Cases that temporarily cease treatment and later return should have an immediate treatment update submitted if it has been longer than 6 months since the last update was submitted.
- c) **Mental Health Treatment Review** – Depending upon the nature of the crime, many victims will evidence reasonable stabilization following six months to a year of continuous care. Cases that fail to show reasonable stabilization during this time period may be subject to review in order to be eligible for continued compensation.

Reimbursement Rates & Limits:

- a) Current reimbursement rates are \$85 per 1-hour session for doctoral-level therapists (psychologists, psychiatrists, and other qualified M.D.s), \$75 per 1-hour session for masters-level therapists (e.g., LCSW, LPC, LMFT), and \$30 per group for group therapy. Initial psychiatric diagnostic interview sessions (CPT code 90791) are reimbursed at a maximum of 1.5 the hourly rate and limited to 1 per therapist.
- b) Claimants are eligible for up to \$2500 in outpatient mental health services for the life of the case. Application for extended outpatient mental health compensation of up to an additional \$2500 is available, but is subject to review. Based upon research related to the treatment outcome of trauma-related conditions, it is anticipated that the majority of victims will achieve reasonable stabilization within 6 months of viable treatment. Therefore, applications for extended treatment will be carefully reviewed for medical and/or clinical necessity, as well as the efficacy of past and proposed treatment by the provider.

Payments & Expense Verification:

- a) Reimbursements from the CVRB are made after all other sources of payments are made. When insurance is available, evidence must be provided that insurance has been processed and applied accordingly (this includes out-of-network benefits). The therapist should clearly indicate when there are no insurance or other third-party payers available for compensation.
- b) The board has no contract with providers, and thus does not stipulate “allowable” charges. However, the CVRB will only reimburse the difference between the total amount of third-party payments (e.g., insurance payments) and the board’s per-session limit.

Eligible Claimants:

- a) **Primary Victim** – any individual directly victimized by a criminal activity
- b) **Secondary Victim** – any direct family member, or a person in a close relationship (i.e., living in home), to a victim of homicide. A direct family member of a sexual abuse victim may also qualify as a secondary victim, but is only eligible for compensation of conjoint counseling expenses (i.e. counseling that also involves the primary sexual abuse victim)

CLAIM FORM FOR MENTAL HEALTH EXPENSES

THIS FORM IS TO BE COMPLETED BY THE CLAIMANT

CVR NUMBER: _____ Victim Name: _____

Claimant Name: _____

Your claim investigator is: _____ Phone: _____

NOTE: Neither the CVR Board nor the Sheriff's office is responsible for your bills.

Neither the Board nor the Sheriff's office is to be listed as the guarantor on the invoice or statement.

STEP 1. ANSWER THESE QUESTIONS ABOUT YOUR EXPENSES.

1. A. Are you responsible for any of these bills? Yes No, then who? _____

B. If not, have you paid all or part of them anyway? Yes No

NOTE: If you answered NO to questions 1A or 1B; stop here. You cannot submit a claim for this expense.

If you answered YES to either question, please continue.

2. Complete the following information for all insurance and/or benefit (**including Medicare**) plans **which might cover these expenses**.

If you have no insurance, please write "**None**" for company name.

Company Name _____	Phone _____
Policy Number _____	Group Number _____
Address _____ (Street, City, State, & Zip Code)	

STEP 2. LIST ALL EXPENSES. Include **current itemized** bills from the mental health provider. Do **not** include bills paid-n-full by an insurance company.

Provider Name	Total Bill +	Ins. Pmts/Ins. Adj., Other Pmts. -	Amount paid by Claimant -	Amount Owed to Providers =

YOU MUST ATTACH A COPY OF THE ITEMIZED BILL **AND** INSURANCE SETTLEMENT FOR EACH EXPENSE CLAIMED.

FOR MEDICAL MILEAGE: Identify Mental Health Provider, dates of visits, miles round trip. The dates listed below must correspond with the documentation listed above. Only claim trips of 20 or more miles one-way for reimbursement.

NAME OF MEDICAL PROVIDER	DATES OF VISIT(s)	MILES/ROUND TRIP
_____	_____	_____
_____	_____	_____
_____	_____	_____

STEP 3.
CLAIMANT SIGNATURE _____ **DATE** _____

SEND THIS FORM AND REQUIRED ATTACHMENTS TO YOUR CLAIM INVESTIGATOR.

Louisiana Crime Victims Reparations Board

Mental Health Treatment - INITIAL PLAN

THIS FORM IS TO BE COMPLETED BY THERAPIST WITHIN THE FIRST 4 WEEKS OF TREATMENT

CVR NUMBER: _____

VICTIM NAME: _____

CLAIMANT NAME: _____

ADDRESS: _____

VICTIM SSN: _____

DATE OF CRIME: _____

CLAIMANT INSTRUCTIONS:

- 1) Give this form to the therapist and ask that it be returned to you, along with itemized bills, once it is completed.
- 2) Attach the completed form to your claim.

PROVIDER INSTRUCTIONS:

- 1) Complete BOTH PAGES of this form and return, along with itemized bills, to the claimant or the claims investigator in your local Sheriff's Office.
- 2) **If insurance is available and is being used, it must be processed and declared before seeking compensation from CVR. This includes use of Medicare, Medicaid, or any other government source of funding for services such as state or federal grants. Submission of EOBs is recommended.**
- 3) **If insurance, Medicare, or Medicaid is available but is not being processed because you are not a contracted provider, please indicate this clearly in the space for insurance below.**
- 4) ****Please note that the CVR is a 3rd party payer of last resort and may be able to help victims with crime-related expenses such as mental health counseling. However, the CVR is NOT to be considered a guarantor for any services provided, and should never be listed as the entity responsible for payment on any invoicing.****

DESCRIBE CLINICAL SYMPTOMS/DIAGNOSIS RELATED TO CRIME: _____

LIST PRIOR DIAGNOSES/TREATMENT: _____

DSM-IV-R DIAGNOSES: AXIS I _____ AXIS II _____ AXIS III _____ AXIS IV _____ AXIS V (Current GAF) _____

DATE TREATMENT BEGAN: ____/____/____ ESTIMATED RESOLUTION DATE: ____/____/____

INSURANCE INFORMATION (INCLUDING MEDICAID) * IF INSURANCE IS AVAILABLE IT MUST BE FILED

INSURANCE NAME: _____ POLICY NO _____

ADDRESS _____

CITY _____ ST _____ ZIP _____ PHONE (____) _____

CERTIFICATION: **Have you received any federal funds to provide services (i.e., VOCA, VAWA grants)?** () Yes
() No

SIGNATURE OF LICENSED PROVIDER

TERMINAL DEGREE

LICENSE NO.

PRINTED NAME

TELEPHONE NO.

DATE

ADDRESS

CITY

ST

ZIP

Are you a Medicaid Provider? (YES or NO) _____

PLEASE COMPLETE PAGE 2 ALSO

Mental Health Treatment - INITIAL PLAN

Patient Name _____

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- 1) List targeted problem areas for this client that are related to their victimization.
- 2) For each problem area, list specific (i.e., quantifiable) goals of treatment.
- 3) Specifically describe how treatment goals will be accomplished via treatment interventions.
- 4) For each problem area, list an estimated resolution date. **(PLEASE NOTE THAT A MORE DETAILED TREATMENT UPDATE FORM WILL BE REQUIRED AFTER 6 MONTHS (calendar days).**

Problem Areas	Treatment Goals	Interventions	Est. Resolution Date

March 11, 2014

Revised: August 12, 2014

Louisiana Crime Victims Reparations Board
MENTAL HEALTH TREATMENT UPDATE
[Confidential under L.R.S. 46:1806(C)(2)]

PLEASE NOTE: Completion of this form is required to show the necessity of continued treatment, and should be completed after the first 6 months of treatment and every 6 months thereafter.

While many victims may benefit from long-term therapy, the Crime Victims Reparations Board is able to provide compensation only for therapy that is necessary to reduce significant risk to a victim and/or restore a victim to a reasonable level of functioning. This may or may not be a level that is equal to the victim's functioning prior to the crime.

IDENTIFYING INFORMATION:

Victim Name: _____ Soc. Sec. No: _____

Claimant Name: _____ Date of Crime: _____

Therapist Name: _____ Claim No: _____

Therapist Signature: _____ Date: _____

Therapist Federal Employer Identification Number: _____

DIAGNOSES:

Axis I: _____

Axis II: _____

Axis III: _____ Current GAF _____

FUNCTIONAL IMPAIRMENTS:

(Rate the severity of impairment in each area below, and describe how the above symptoms impair functioning or place the victim at risk)

1 = MILD (impacts quality of life but no significant impairment of day to day functioning)

2 = MODERATE (significant impact on quality of life and/or day to day functioning)

3 = SEVERE (profound impact on quality of life and day to day functioning)

AREA	SEVERITY	DESCRIPTION
Job/School	_____	_____
Relationships/Family	_____	_____
Other _____	_____	_____

SYMPTOMS & PROBLEMS:

(Check all that substantiate Axis I & II diagnoses and rate the severity of each)

1 = MILD (impacts quality of life but no significant impairment of day to day functioning)

2 = MODERATE (significant impact on quality of life and/or day to day functioning)

3 = SEVERE (profound impact on quality of life and day to day functioning)

<input type="checkbox"/> Anxiety	1	2	3	<input type="checkbox"/> Irritability	1	2	3	<input type="checkbox"/> Lability	1	2	3
<input type="checkbox"/> Appetite Disturbance	1	2	3	<input type="checkbox"/> Independent Living Problems	1	2	3	<input type="checkbox"/> Bingeing/Purging	1	2	3
<input type="checkbox"/> Bizarre Behavior	1	2	3	<input type="checkbox"/> Poor Interpersonal Skills	1	2	3	<input type="checkbox"/> Laxative/Diuretic Abuse	1	2	3
<input type="checkbox"/> Conduct Problems	1	2	3	<input type="checkbox"/> Poor Judgment	1	2	3	<input type="checkbox"/> Anorexia	1	2	3
<input type="checkbox"/> Depressed Mood	1	2	3	<input type="checkbox"/> Impaired Memory	1	2	3	<input type="checkbox"/> Circumstantial/Tangential	1	2	3
<input type="checkbox"/> Gender Issues	1	2	3	<input type="checkbox"/> Obsessions/Compulsions	1	2	3	<input type="checkbox"/> Loose Associations	1	2	3
<input type="checkbox"/> Bizarre Ideation	1	2	3	<input type="checkbox"/> Panic Attacks	1	2	3	<input type="checkbox"/> Delusions	1	2	3
<input type="checkbox"/> Low Energy/Anhedonia	1	2	3	<input type="checkbox"/> Paranoid Ideation	1	2	3	<input type="checkbox"/> Hallucinations	1	2	3
<input type="checkbox"/> Psychomotor Retardation	1	2	3	<input type="checkbox"/> Phobia	1	2	3	<input type="checkbox"/> Aggressive Behaviors	1	2	3
<input type="checkbox"/> Poor Concentration	1	2	3	<input type="checkbox"/> Sexual Dysfunction	1	2	3	<input type="checkbox"/> Oppositional Behavior	1	2	3
<input type="checkbox"/> Agitation	1	2	3	<input type="checkbox"/> Sleep Disturbance	1	2	3	<input type="checkbox"/> Other			
<input type="checkbox"/> Elimination Disturbance	1	2	3	<input type="checkbox"/> Somatization	1	2	3	_____	1	2	3
								_____	1	2	3

CURRENT RISK FACTORS:

SUICIDALITY: None Ideation Plan Intent w/o means Intent with means

HOMOCIDALITY: None Ideation Plan Intent w/o means Intent with means

IMPULSE CONTROL: Sufficient Moderate Minimal Inconsistent Explosive

MEDICAL RISKS: Yes No If Yes, explain _____

OTHER: _____

TREATMENT GOALS:

(List specific goals directed at reducing risk and impairment to functioning specified above. Also rate the progress toward meeting each goal using the scale below)

- N – NEW GOAL
- 1 – MUCH WORSE
- 2 – SOMEWHAT WORSE
- 3 – NO CHANGE
- 4 – SLIGHT IMPROVEMENT
- 5 – GREAT IMPROVEMENT
- R – RESOLVED

Treatment Goals	Treatment Methods	Progress (since last report)	Expected Resolution Date

Claimant Signature

Date