AETNA BETTER HEALTH®

d/b/a Aetna Better Health of Louisiana

Policy

Policy Name:	Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR) Services	Page:	1 of 14
Department:	Medical Management	Policy Number:	7100.50
Subsection:	Prior Authorization	Effective Date:	06/01/2018
Applies to:	■ Medicaid Health Plans		

PURPOSE:

The purpose of this policy is to define Aetna Better Health's business standards for the prior authorization of Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR) Services.

STATEMENT OF OBJECTIVE:

Objectives of the CPST/PSR prior authorization process are to:

- Accurately document all CPST/PSR authorization requests
- Verify that a member is eligible to receive CPST/PSR services at the time of the request and on each date of service
- Assist providers in providing appropriate, timely, and cost-effective CPST/PSR services
- Verify the practitioner's or provider's network participation
- Evaluate and determine medical necessity and/or need for additional supporting documentation
- Collaborate and communicate as appropriate for the coordination of members' care
- Research a member's authorization history before approving CPST/PSR services to avoid duplicating services the member is already receiving
- Place appropriate limits on CPST/PSR on the basis of medical necessity or for the purposes of utilization management provided the services furnished can reasonably be expected to achieve their purpose in accordance with 42 CFR §438.210
- Establish protocol for working with out-of-network CPST/PSR providers to facilitate SCA's as needed to secure appropriate treatment for members

DEFINITIONS:

Child and Adolescent Service Intensity Instrument (CASII)	A tool to determine the appropriate level of care placement for a child or adolescent; developed by the American Academy of Child and Adolescent Psychiatry (AACAP)'s Work Group on Community Systems of Care and the American Association of Community Psychiatrists (AACP). Developed from the CALOCUS with training requirements for reliability.

Level of Care Utilization System (LOCUS)©	A nationally recognized clinical guideline for making decisions regarding medical necessity of behavioral health treatment. LOCUS was developed for adults by the American Association of Community Psychiatrists (AACP).
MCG®	MCG, including Chronic Care Guidelines, are evidence-based clinical guidelines that are updated annually. They support prospective, concurrent, and retrospective reviews; proactive care management; discharge planning; patient education, and quality initiatives.

LEGAL/CONTRACT REFERENCE:

The CPST/PSR prior authorization process is governed by:

- RFP # 305PUR-LDHRFP-BH-MCO-2014-MVA, Section 8.0
- Applicable federal and state laws, regulations and directives, including the confidentiality of member information (e.g., Health Insurance Portability and Accountability Act [HIPAA])
- National Committee for Quality Assurance (NCQA) Standards and Guidelines for the Accreditation of Health Plans
- Policy 7000.30 Process for Approving and Applying Medical Necessity Criteria
- LDH Behavioral Health Services Provider Manual

FOCUS/DISPOSITION:

Aetna Better Health provides CPST/PSR services as part of a comprehensive specialized psychiatric program available to all child, adolescent, and adult members with significant functional impairments resulting from an identified mental health disorder diagnosis. The medical necessity for these rehabilitative services must be determined by and services recommended by a licensed mental health professional (LMHP) or physician, or under the direction of a licensed practitioner, to promote the maximum reduction of symptoms and restoration to his/her best age-appropriate functional level.

CPST/PSR for Children and Adolescents

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

- Restoration of positive family/caregiver relationships;
- Prosocial peer relationships;
- Community connectedness/social belonging; and
- The ability to function in a developmentally appropriate home, school, vocational and community settings.

Services should provide skill building and supports that build on existing strengths and target goals related to these key developmental needs and protective factors. Children/adolescents who are in need of specialized behavioral health services will be served within the context of the family and not as an isolated unit. Services provided to children and adolescents must include communication and coordination with the family and/or legal guardian, including any agency legally responsible for the care or custody of the child. The majority of services will be delivered with the parent/caregiver present. Following the initial authorization, services may not be reauthorized if a member's parent/caregiver is not engaged in treatment and there is documentation that the member is receiving services outside the context of their family. Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the child's/adolescent's medical record.

CPST/PSR for Adults

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. This 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 and to prevent 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, or a co-occurring diagnosis of mental health and substance use. Services may be provided at a facility, in the community, or in the individual's place of residence as outlined in the treatment plan. Services may be furnished in a nursing facility only in accordance with policies and procedures issued by LDH. Services will not be provided at an institute for mental disease (IMD). There will be recipient involvement throughout the planning and delivery of services.

Aetna Better Health Responsibilities

The chief medical officer (CMO) is responsible for directing and overseeing the Aetna Better Health prior authorization of CPST/PSR function. The Prior Authorization department is principally responsible for carrying out the day-to-day operations (e.g., evaluating requests, documenting requests and decisions, and issuing authorization numbers for approved requests) under the supervision of a medical director or designated licensed clinical professional qualified by training, experience and certification/licensure to conduct the utilization management (UM) functions in accordance with state and federal regulations.[1] Other departments approved by the CMO (such as Care Management and Concurrent Review) may issue authorizations for specific services within their areas of responsibility per contractual requirements. Departments with authority to authorize services will maintain a postal address, direct telephone, fax number, or electronic interchange (if available) for receiving and responding to notifications and service authorization requests. Only a health care professional may make determinations regarding the medical necessity of health care services during the course of utilization review.

When initiating or returning calls regarding UM issues, Aetna Better Health requires UM staff to identify themselves by name, title, and organization name;[2] and upon request, verbally inform member, facility personnel, the attending physician and other ordering practitioners/providers of specific UM requirements and procedures. Aetna Better Health must triage incoming standard and expedited requests for services based upon the need for urgency

[1] NCQA HP 2018/2019 UM4 A1
[2] NCQA HP 2018/2019 UM3 A3

due to the member's health condition. Aetna Better Health must identify the qualification of staff who will determine medical necessity.[3]

Nonclinical staff is responsible for:[4]

- Documenting incoming prior authorization requests and screening for member's enrollment, member eligibility, and practitioner/provider affiliation
- Forwarding to clinical reviewers any requests that require a medical necessity review

Clinical reviewer's responsibilities include:[5]

- Identifying service requests that may potentially be denied or reduced on the basis of medical necessity
- Forwarding potential denials or reductions to the CMO or designated medical director for review
- If services are to be denied or reduced:
  - Providing written notification of denials/reductions to members
  - Notifying the requesting practitioner/provider and member of the decision to deny, reduce or terminate reimbursement within the applicable time frame
  - Documenting, or informing data entry staff to document the denial decision in the business application system prior authorization module

Medical Director Reviewer Responsibilities

Authorization requests that do not meet criteria for the requested service will be presented to the behavioral health medical director for review. The behavioral health medical director conducting the review must have clinical expertise in treating the member's condition or disease and be qualified by training, experience and certification/licensure to conduct the prior authorization functions in accordance with state and federal regulations. The behavioral health medical director will review the service request, the member's need, and the clinical information presented. Using the approved criteria and the behavioral health medical director's clinical judgment, a determination is made to approve, deny or reduce the service. Only the behavioral health

[3] RFP # 305 PUR-LDHRFP-BH-MCO-2014-MVA, Section 8.1.13
[4] NCQA HP 2018/2019 UM4 A2
[5] NCQA HP 2018/2019 UM4 A1-2

medical director can reduce or deny a request for CPST/PSR based on a medical necessity review.[6]

If all applicable medical necessity criteria are not clear enough to make a determination or the requested service is not addressed by the standard criteria or Aetna Clinical Policy Bulletins (CPBs), the behavioral health medical director may submit a request for a position determination to the Aetna Clinical Policy Review Unit, using the Emerging Technology Review/Medical Review Request form. The Aetna Clinical Policy Review Unit will research literature applicable to the specific request and, when a determination is reached, will respond to the CMO/designated medical director.

When criteria are present but unclear in relation to the situation, the reviewing behavioral health medical director may contact the requester to discuss the case or may consult with a board-certified physician from an appropriate specialty area before making a determination of medical necessity.[7] Practitioners/providers are notified in the denial letter (i.e., Notice of Action [NOA]) that they may request a peer-to-peer consultation to discuss denied or reduced service authorizations with the behavioral health medical director reviewer by calling Aetna Better Health. All behavioral health medical director discussions and actions, including discussions between medical directors and treating practitioners/providers are to be documented in the Aetna Better Health authorization system.[8]

As part of Aetna Better Health's appeal procedures, Aetna Better Health will include an Informal Reconsideration process that allows the member (or provider/agent on behalf of a member with the member's written consent) a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.[9]

[6] NCQA HP 2018/2019 UM4 F1
[7] NCQA HP 2018/2019 UM4 A2
[8] NCQA HP 2018/2019 UM7 D
[9] RFP # 305 PUR-LDHRFP-BH-MCO-2014-MVA, Section 8.5.4.1.3.1 and 8.5.4.1.3.2

Prior Authorization of CPST/PSR Services

Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR) require initial and follow-up prior authorization. Providers are required to use the Child Adolescent Level of Care Utilization System (CALOCUS) or the Child and Adolescent Service Intensity Instrument (CASII) for members ages six (6) through eighteen (18) receiving CPST and/or PSR and the Level of Care Utilization System (LOCUS) for members age nineteen (19) and older receiving CPST and/or PSR. The CASII/CALOCUS is not required for members under the age of six (6) years of age. CPST/PSR providers must use assessment forms that collect all data elements necessary to rate the CASII/CALOCUS/LOCUS. Assessments will be performed and signed by an LMHP, and for children and adolescents will be completed with the involvement of the primary caregiver. Assessments must be performed at least every three hundred sixty-four (364) days or as needed, such as any time there is a significant change to the member's circumstances.
Providers must also submit CASII/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. For members ages 6-20, a CASII/CALOCUS/LOCUS rating must be completed and submitted every one hundred eighty (180) days until discharge.

CPST and PSR authorizations are for up to one hundred eighty (180) days. Aetna Better Health turn-around time (TAT) is consistent with LDH expectation of eighty percent (80%) within five (5) business days and one hundred percent (100%) within fourteen (14) days or seventy-two (72) hours when urgent.

The treatment plan should be submitted within thirty (30) days of the initial authorization request. Treatment plans will be specific, time-sensitive, based on the assessed needs, built on strengths, include a crisis mitigation plan, and developed by an LMHP or physician in collaboration with direct care staff, the member, family, and natural supports. Treatment plans will contain goals and interventions targeting areas of risk and need identified in the assessment. The place of service should be documented in the treatment plan. All team members, including the member and family, will sign the treatment plan. The member will receive a copy of the plan upon completion. Treatment plans should be updated at least every one hundred eighty (180) days.

Subsequent Reviews

Providers will have an established process for each member to monitor their progress with accomplishing goals and objectives. Following the initial assessment and initial authorization, this process will be facilitated by the member's LMHP in collaboration with provider staff, the member, family/caregiver, and other stakeholders to determine if the member is making progress. When it is determined that a member is making limited to no progress, then the LMHP, in collaboration with the treatment team, the member and family, should update the treatment plan including the goals, objectives and interventions to make sure that each service contact increases the possibility that a member will make progress. An LMHP must also complete a monthly review of all progress notes. Only staff that perform the service may write the progress note and sign it.

Medical Necessity Criteria

In addition to the LDH Behavioral Health Services Provider Manual, the primary medical necessity criteria used to authorize CPST/PSR services for members ages six (6) through eighteen (18) is the CASII (formerly known as the CALOCUS). The primary medical necessity criteria used to authorize CPST/PSR services for members age nineteen (19) and older is LOCUS. The primary criteria for CPST for members ages zero (0) through five (5) and the secondary criteria for CPST for members age six (6) and older is 20th Edition MCG Guideline Mental Health Support Services ORG: B-809-T (BHG). The primary criteria for PSR for members ages zero (0) through five (5) and the secondary criteria for CPST for members age six (6) and older is 20th Edition MCG Guideline Psychosocial Rehabilitation ORG: B-812-T (BHG).

Aetna Better Health requires that the member's situation and expectations are appropriate for CPST and PSR as indicated by all of the following:

- Recommended treatment is necessary and not appropriate for less intensive care (for example, the member requires assistance in accessing services and documented behavior, symptoms, or risk is inappropriate for outpatient office care or traditional case management);
- Member is assessed as not at risk of imminent danger to self or others;

- Primary treatments (such as pharmacotherapy or psychosocial therapy) are insufficient to meet care needs;
- Targeted symptoms, behaviors, and functional impairments related to underlying behavioral health disorder have been identified and are appropriate for mental health support services and/or psychosocial rehabilitation;
- Treatment plan addresses comorbid medical, psychiatric, and substance use disorders, and includes coordination of care with other providers and community-based resources, as appropriate;
- Treatment plan includes explicit and measurable recovery goals that will define member improvement, with regular assessment that progress toward goals is occurring or that condition would deteriorate in absence of continued mental health support services and/or psychosocial rehabilitation;
- Treatment plan engages family, caregivers, and other people impacted by and in position to affect member behavior, as appropriate;
- Treatment intensity (such as number of hours per week) and duration is individualized and designed to meet needs of member, and will be adjusted according to member's response to treatment and ability to participate effectively;
- Member is expected to be able to adequately participate in and respond as planned to proposed treatment.

For members age twenty-one (21) and older:

- Members must have a diagnosable mental, behavioral, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities
- Members must have a level of care score of at least a three (3) on the LOCUS
- Members must have a functional status domain score of at least a three (3) on the LOCUS
- Aetna Better Health utilization review staff authorizes up to ninety-six (96) units per one hundred eighty (180) days for members with a LOCUS level of care score of three (3).

Requests for more than ninety-six (96) units of CPST/PSR per one hundred eighty (180) days require medical director review.

Limitations/Exclusions of CPST/PSR:

The following services will be excluded from CPST/PSR coverage and reimbursement:

- Components that are not provided to, or directed exclusively toward, the treatment of the Medicaid eligible individual.
- Services providers at a work site, which are job tasks oriented and not directly related to the treatment of the member's needs.
- These rehabilitation services will not duplicate any other Medicaid State Plan service or service otherwise available to the member at no cost.
- 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.
- Academic tutoring, teaching job related skills, vocational rehabilitation, transportation, staff training, preparation for group activities or individual sessions, phone contact including attempts to reach the member to schedule, confirm, or cancel an appointment, staff supervision, completion of paper work when the recipient is not present, team meetings and collaboration exclusively with staff without the member, recreational outings, observation of the recipient including the school setting or community settings, staff research, summer camp, or other non-therapeutic activity with the member not present and not tied to the member's treatment plan.

Member Choice Form and Process:

Members may only receive CPST/PSR services from one (1) provider at a time with the following exceptions:

- A member is receiving tenancy support through the Permanent Housing program, and/or
- The behavioral health medical director makes the determination that it is medically necessary and clinically appropriate to receive services from more than one (1) CPST/PSR provider. The justification must be supported by the member's assessment and treatment plan. This decision must be reviewed at each reauthorization. If a member is receiving services from more than one CPST/PSR provider, the providers must have documented coordination of care.

All members 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. The Member Choice Form must be fully completed, signed by all parties, and received prior to the start of services. If a member is receiving services from an CPST/PSR provider and a request is received for a new CPST/PSR provider with a member choice form, the currently authorized provider will be notified and their authorization will be given an end date; a minimal amount of service overlap between the two providers may be allowed to prevent a gap in services. If the currently authorized provider states that the member is still receiving services from them, they also have the option to submit a Member Choice Form. At that point the member will be contacted and will have to choose one (1) provider to continue with. The other provider will be notified and their authorization will be given an end date; a minimal amount of service overlap between the two providers may be allowed to prevent a gap in services.

Out-Of-Network Requests

When a request from an out of network CPST/PSR provider is received, the prior authorization clinical staff attempts to identify in-network CPST/PSR providers that can service the member. If they are able to locate in-network CPST/PSR providers who can service the member, the request is sent to the medical director for review and may be denied if there is the availability of in-network CPST/PSR providers. If the prior authorization clinical staff is unable to locate an in-network CPST/PSR provider who can service the member, the request may be approved. If the member is new to Aetna Better Health and is currently receiving services from the provider, the request will be approved for at least sixty (60) days for continuity of care. If the prior authorization clinical staff is unable to locate an in-network CPST/PSR provider who can service the member, the request will be approved.

If the out-of-network CPST/PSR request is approved, the clinical staff notifies the network department and requests a single case agreement (SCA) be completed with the provider. Facility specialty is verified by licensure and accreditation in lieu of credentialing for the SCA. Network participation may be considered should the provider meet Aetna Better Health quality standards.

OPERATING PROTOCOL:

Systems

The business application system has the capacity to electronically store and report all service authorization requests, decisions made by Aetna Better Health regarding the service requests, clinical data to support the decision, and timeframes for notification to practitioners/providers and members of decisions.

Prior authorization requests, decisions and status are documented in the business application system prior authorization module.

Measurement

The Prior Authorization department measures:

- Volume of requests received by telephone, facsimile, mail, and website, respectively
- Service level
- Timeliness of decisions and notifications
- Process performance rates for the following, using established standards:
  - Telephone abandonment rate: under five percent (5%)
  - Average telephone answer time: within thirty (30) seconds
  - Consistency in the use of criteria in the decision making process among Prior Authorization staff measured by annual inter-rater reliability audits
  - Consistency in documentation by department file audits at least quarterly
- Percentage of prior authorization requests approved
- Trend analysis of prior authorization requests approved
- Percentage of prior authorization requests denied
- Trend analysis of prior authorization requests denied

Reporting

- Monthly report to the CMO of the following:
  - Number of incoming calls
  - Call abandonment rate
  - Trend analysis of incoming calls

- Average telephone answer time
- Total authorization requests by source – mail, fax, phone, web
- Number of denials by type (administrative/medical necessity)

- Utilization tracking and trending is reviewed by the CMO on a monthly basis and is reported at a minimum of quarterly to the QM/UM Committee
- Annual report of inter-rater reliability assessment results

INTER-/INTRA-DEPENDENCIES:

Internal

- Claims
- Chief medical officer/medical directors
- Finance
- Information Technology
- Medical Management
- Member Services
- Provider Services
- Quality Management
- Quality Management/Utilization Management Committee

External

- Members
- Practitioners and providers
- Regulatory bodies

Aetna Better Health

Richard C. Born
Chief Executive Officer

Madelyn M. Meyn, MD
Interim Chief Medical Officer

Review/Revision History	
01/2019	Updated medical necessity criteria, member choice form, and out of network request sections
02/2019	Updated medical necessity criteria section
06/2019	Changed "Mental Health Rehabilitation (MHR)" to "Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR);" updated Medical Director Reviewer Responsibilities, Prior Authorization of CPST/PSR Services, and Medical Necessity Criteria sections; updated NCQA references, logo, and CMO signatory line