Document ID: AETAMA-081917	Title: Aetna Medicaid Administrators 7100.50 Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR) Services Louisiana Policy	
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PURPOSE

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

SCOPE

The scope of this policy applies to the Louisiana Prior Authorization staff and all colleagues processing Louisiana authorization requests for Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR) Services.

POLICY

It is the policy of the plan that specific state directives, in addition to MCG® criteria are used when processing authorization requests for Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR) Services. Louisiana state qualifications, authorization and documentation requirements must be met. It defines additional Louisiana state qualifications and authorization and documentation requirements.

STANDARD

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 to promote the maximum reduction of symptoms and restoration to his/her best age-appropriate functional level.

CPST is a goal-directed support and solution focused intervention, which focuses on reducing the disability resulting from mental illness, restoring functional skills of daily living, building natural supports, and achieving identified person-centered goals or objectives as set forth in the individualized treatment plan. Components of CPST may include ongoing monitoring of needs, counseling, and clinical psychoeducation.

PSR services are designed to assist the individual with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their mental illness. PSR will be manualized or delivered in accordance with a nationally accepted protocol; components may include skills building such as independent living skills, social and interpersonal skills, and daily living skills.

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. While a child/adolescent is receiving rehabilitation services, a parent/caregiver and necessary family members should be involved in medically necessary services. The treatment plan and progress notes must indicate the member's parent/caregiver and family are involved in treatment. Following initial authorization, if a member is not progressing and the family is not engaged or participating in treatment, the treatment plan and approach should be updated to assure family involvement before reauthorization is considered.

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 intended for an individual with a mental health diagnosis only, a co-occurring diagnosis of mental health and substance use disorder or a co-occurring diagnosis of mental health and intellectual/developmental disability.

Prior Authorization of CPST/PSR Services

Each member will be assessed and will have a treatment plan developed based on that assessment. Assessments will be performed by an LMHP, and for children and adolescents will be completed with the involvement of the primary caregiver. CPST and PSR require initial and follow-up prior authorization. Providers are required to use the Child Adolescent Level of Care Utilization System (CALOCUS) 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 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 CALOCUS/LOCUS. **The standard authorization period for CPST and PSR is six (6) months. The following documents must be submitted with authorization requests for CPST/PSR:**

For under age 21:

- **CALOCUS/LOCUS (for 6 years and up) scoresheet signed by an LMHP, updated every 180 days, 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;**
- **Assessment signed by an LMHP updated every 180 days;**
- **Treatment plan signed by an LMHP updated every 180 days including a crisis mitigation plan;**
- **Signed Freedom of Choice form (Only requested on initial request or a change in provider);**
- **Progress Summaries (submitted for concurrent reviews only).**

- **For age 21 and above:**
    - **LOCUS scoresheet signed by an LMHP updated every 365 days, 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;**
    - **Assessment signed by an LMHP updated every 365 days;**
    - **Treatment plan signed by an LMHP updated every 180 days including a crisis mitigation plan;**
    - **Signed Freedom of Choice form (Only requested on initial request or a change in provider);**
    - **Progress Summaries (submitted for concurrent reviews only).**

For adults, assessments must be performed prior to receiving CPST and/or PSR and at least once every 365 days until discharge. For youth, assessments must be performed prior to receiving CPST and/or PSR and at least once every 180 days until discharge. Assessments must also be performed any time there is a significant change to the member's circumstances.

Providers must also submit CALOCUS/LOCUS ratings on a form that includes the rating in each dimension, the criteria to support the rating, independent criteria, the composite score, the level of care, a section to document notes, a signature line with credentials, and a rating date. For members ages 6-20, a 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 with the initial authorization request. The goal of the treatment plan is to help ensure measurable improved outcomes, increased strengths, a reduction in risk of harm to self or others, and a reduction emergency department use or in the risk of out of home placements to inpatient and residential care. Treatment plans will be Specific, Measurable, Achievable, Realistic, Time-oriented (SMART), 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. Treatment plans should be updated at least every one hundred eighty (180) days.

Individuals rendering the assessment and treatment planning components of CPST services must be an LMHP. As a part of treatment planning, LMHPs will monitor progress with accomplishing goals and objectives. When it is determined that a member is making limited to no progress, the LMHP, in collaboration with the treatment team, member and family/caregiver, should update the treatment plan to increase the possibility that a member will make progress. If the member continues to make limited to no progress, the LMHP will

consider if MHR services should continue or if a referral to a different level of service delivered by the same or a different provider may improve progress. Effective January 1, 2023, individuals rendering all other components of CPST services must be an LMHP, Provisionally Licensed Professional Counselor (PLPC), Provisionally Licensed Marriage and Family Therapist (PLMFT), Licensed Master Social Worker (LMSW), Certified Social Worker (CSW) or a psychology intern from an APA approved internship program.

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 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 the most current edition of the MCG guidelines 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 the most current edition of the MCG guidelines Psychosocial Rehabilitation ORG: B-812-T (BHG). The criteria outlined can be accessed through the referenced portal, https://mcg.aetna.com.

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
- A member with longstanding deficits who does not experience any acute changes in their status and has previously met the criteria stated above regarding LOCUS scores, but who now meets a level of care of two (2) or lower on the LOCUS, and needs subsequent medically necessary services for stabilization and maintenance at a lower intensity, may continue to receive CPST services and/or PSR, if deemed medically necessary by the medical director
- Aetna Better Health utilization review staff authorizes up to two hundred eight (208) units total of CPST/PSR per one hundred eighty (180) days for members with a LOCUS level of care score of three (3); requests for more than two hundred eight (208) units total of CPST/PSR per one hundred eighty (180) days for a member with a LOCUS score of three (3) require medical director review. **The medical director may approve additional units if clinically indicated.**
- Aetna Better Health utilization review staff authorizes up to three hundred twelve (312) units total of CPST/PSR per one hundred eighty (180) days for members with a LOCUS level of care score of four (4) or more. **The medical director may approve additional units if clinically indicated.**

- All requests for more than three hundred twelve (312) units total of CPST/PSR per one hundred eighty (180) days require medical director review with the exception of Permanent Supportive Housing (PSH) CPST/PSR. The medical director may approve additional units if clinically indicated.

Limitations/Exclusions of CPST/PSR:

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

- Activities provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide, or an academic tutor;
- Childcare provided as a substitute for the parent or other individuals responsible for providing care and supervision;
- Respite care;
- Teaching job related skills (management of symptoms and appropriate work habits may be taught);
- Vocational rehabilitation (vocational assessment, job development, job coaching); CPST and PSR can include services, such as interpersonal skills, anger management, etc.) that enable the beneficiary to function in the workplace;
- Transportation;
- Staff training;
- Phone contacts including attempts to reach the member by telephone to schedule, confirm, or cancel appointments;
- Staff supervision;
- Completion of paperwork when the member and/or their significant others are not present. Requiring members to be present only for documentation purposes is not reimbursable;
- Team meetings and collaboration exclusively with staff employed or contracted by the provider where the member and/or their family/caregivers are not present;
- Observation of the member (e.g., in the school setting or classroom);
- Staff research on behalf of the member;
- Providers may not set up summer camps and bill the time as a mental health rehabilitation service;
- All contacts by salaried professionals such as supervisors, administrators, human resources staff, receptionists, etc. that are included in the rate (including meetings, travel time, etc.), are considered indirect costs;
- Contacts that are not medically necessary;
- Covered services that have not been rendered;
- Services rendered that are not in accordance with an approved authorization;
- Interventions not identified in the member’s treatment plan;
- Services provided to children, spouse, parents, or siblings of the eligible member

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 member's treatment plan;

- Services provided that are not within the provider's scope of practice;
- Any art, movement, dance, or drama therapies; and
- Any intervention or contact not documented

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 ofcare.

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 **that Aetna has confirmed as accepting new patients**. In such cases, the clinical staff will provide the member with a list of at least three in-network CPST/PSR providers, including their contact information, who are within an appropriate radius of the member's residence and meet availability requirements. 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.

APPLICABLE CPT/HCPCS CODES

This policy applies the additional definitions, qualifications, criteria and documentation requirements to the procedure codes listed below. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT/HCPCS	Description	Modifiers
H0036	COMMUNITY PSYCHIATRIC SUPPORTIVE TREATMENT - INDIVIDUAL OFFICE	
H0036	COMMUNITY PSYCHIATRIC SUPPORTIVE TREATMENT - INDIVIDUAL COMMUNITY	U8
H0036	COMMUNITY PSYCHIATRIC SUPPORTIVE TREATMENT - PSH INDIVIDUAL OFFICE	TG
H0036	COMMUNITY PSYCHIATRIC SUPPORTIVE TREATMENT - PSH INDIVIDUAL COMMUNITY	TG, U8
H2017	PSYCHOSOCIAL REHABILITATION - INDIVIDUAL OFFICE	
H2017	PSYCHOSOCIAL REHABILITATION - INDIVIDUAL COMMUNITY	U8
H2017	PSYCHOSOCIAL REHABILITATION - PSH INDIVIDUAL OFFICE	TG
H2017	PSYCHOSOCIAL REHABILITATION - PSH INDIVIDUAL COMMUNITY	TG, U8
H2017	PSYCHOSOCIAL REHABILITATION - GROUP OFFICE	HQ
H2017	PSYCHOSOCIAL REHABILITATION - GROUP COMMUNITY	HQ, U8
H2017	PSYCHOSOCIAL REHABILITATION PSH GROUP OFFICE	HQ, TG
H2017	PSYCHOSOCIAL REHABILITATION PSH GROUP COMMUNITY	HQ, TG, U8

DEFINITIONS:

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.
Prior Authorization	Process in which providers must obtain approval from prior to services provided.
Child and Adolescent Level of Care Utilization System (CALOCUS©), Version 20	A nationally recognized clinical guideline for making decisions regarding medical necessity for behavioral health treatment. CALOCUS was developed for children and adolescents by the American Association of Community Psychiatrists (AACP).
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).

REVIEW AND REVISION HISTORY

Date	Revision No.	Reason for Change	Sections Affected
06/2018	New Policy		
01/2019	1	Added additional language from Aetna Better Health of Louisiana Prior Authorization policy, updated contract and NCQA references, updated MCG edition, added a reference for language included from the LDH Behavioral Health Services manual, corrected number of hours of emergent CI that can be authorized without medical director review to reflect the per diem CPT code Updated medical necessity criteria, member choice form, and out of network request sections	
02/2019	2	Updated medical necessity criteria section	All
06/2019	3	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	All

03/2020	4	Updated Focus/Disposition section, Prior Authorization of CPST/PSR Services section, Medical Necessity Criteria section and CMO signatory line	All
07/2020	5	Removed CASII criteria and replaced with CALOCUS criteria	All
09/2021	6	Annual review. No changes.	All
10/2022	7	Updated to reflect LDH BH manual draft changes. Removed unnecessary language: Aetna Better Health Responsibilities and Operating Protocol sections.	All
10/2023	8	Annual review; updated signatory lines. Removed unnecessary language from Objectives. Minor updates to language to improve clarity.	All
10/2024	9	New template, Updated MCG edition	All
11/2024	10	Removal of specific MCG language; Updated CEO	All
03/2025	11	Added additional prior authorization language	All

Aetna Better Health of Louisiana

Bridget Galatas
Chief Executive Officer

Antoinette Logarbo, MD
Chief Medical Officer

Jared Wakeman, MD
Behavioral Health Medical Director

Resources

- 2023 Louisiana Medicaid Managed Care Organization Statement of Work
- Louisiana Department of Health (LDH) Behavioral Health Services Provider Manual, Section 2.3: Outpatient Services, Mental Health Rehabilitation Services, Revised 07/07/23

EXHIBIT(S):