



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 11
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 **clinicalbusiness** 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:

- Define CPST/PSR services
- Ensure the hierarchy of medical necessity criteria for CPST/PSR services are utilized appropriately
- Establish procedures for reviewing and rendering determinations for CPST/PSR services prior authorization requests
- ~~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:

MEDICAL MANAGEMENT: Prior Authorization

Revised: TBD10/06/2022



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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).
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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 (AACCP).
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:

- 2023 Louisiana Medicaid Managed Care Organization Statement of Work
- 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~~
- ~~Aetna Medicaid Administrators (AMA) 7000.30 Process for Approving and Applying Medical Necessity Criteria CORPORATE POLICY A-LA Amendment~~
- Louisiana Department of Health (LDH) Behavioral Health Services Provider Manual, ~~Section 2.3: Outpatient Services, Mental Health Rehabilitation Services, Revised 01/12/242022~~

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 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



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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)



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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.

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

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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 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



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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
- 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.
- 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.



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- 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

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;



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- 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 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



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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.



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<u>Review/Revision History</u>	
06/2018	New policy
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
03/2020	Updated Focus/Disposition section, Prior Authorization of CPST/PSR Services section, Medical Necessity Criteria section and CMO signatory line
07/2020	Removed CASH criteria and replaced with CALOCUS criteria
09/2021	Annual review. No changes.
10/2022	Updated to reflect LDH BH manual draft changes. Removed unnecessary language: Aetna — Better Health Responsibilities and Operating Protocol sections.