AETNA BETTER HEALTH®

d/b/a Aetna Better Health of Louisiana

Policy

Policy Name:	**Crisis Intervention (CI) Services**	**Page:**	**1 of 8**
Department:	**Medical Management**	**Policy Number:**	**Unassigned**
Subsection:	**Prior Authorization**	**Effective Date:**	**Pending**
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 Crisis Intervention (CI) Services.

STATEMENT OF OBJECTIVE:

Objectives of the CI prior authorization process are to:

- **Accurately document all CI authorization requests**
- **Verify that a member is eligible to receive CI services at the time of the request and on each date of service**
- **Assist providers in providing appropriate, timely, and cost-effective CI 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**
- **Place appropriate limits on CI 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 CI providers to facilitate SCA's as needed to secure appropriate treatment for members**

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.**

LEGAL/CONTRACT REFERENCE:

The CI 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 2019/2020**
- **Policy 7000.30 Process for Approving and Applying Medical Necessity Criteria**
- **LDH Behavioral Health Services Provider Manual**

FOCUS/DISPOSITION:

Crisis intervention (CI) services are provided to a person who is experiencing a psychiatric crisis and are designed to interrupt and/or ameliorate a crisis experience, through a preliminary assessment, immediate crisis resolution and de-escalation and referral and linkage to appropriate community services to avoid more restrictive levels of treatment. The goals of CIs are symptom reduction, stabilization and restoration to a previous level of functioning. All activities must occur within the context of a potential or actual psychiatric crisis. CI is a face-to-face intervention and can occur in a variety of locations, including an emergency room or clinic setting, in addition to other community locations where the person lives, works, attends school and/or socializes. Components include:

- **A preliminary assessment of risk, mental status and medical stability and the need for further evaluation or other mental health services must be conducted. This includes contact with the member, family members or other collateral sources (e.g., caregiver, school personnel) with pertinent information for the purpose of a preliminary assessment and/or referral to other alternative mental health services at an appropriate level.**
- **Short-term CIs, including crisis resolution and debriefing with the identified Medicaid-eligible individual.**
- **Follow up with the individual and, as necessary, with the individuals' caretaker and/or family members.**
- **Consultation with a physician or with other qualified providers to assist with the individuals' specific crisis.**
  NOTE: The components above are required unless the member is not available due to incarceration, hospitalization, or other unavoidable reason.

Aetna Better Health Responsibilities

The chief medical officer (CMO) is responsible for directing and overseeing the Aetna Better Health prior authorization of CI 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 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**

[1] NCQA HP 2018/2019 UM4 A1
[2] NCQA HP 2018/2019 UM3 A3
[3] RFP # 305PUR-LDHRFP-BH-MCO-2014-MVA, Section 8.1.13
[4] NCQA HP 2018/2019 UM4 A2

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 medical director can reduce or deny a request for CI 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.

[5] **NCQA HP 2018/2019 UM4 A1-2**
[6] **NCQA HP 2018/2019 UM4 F1**

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]

Prior Authorization of CI Services

Crisis Intervention (CI)- Emergent does not require prior authorization but does require notification and authorization within 1 business day of the start of services. CI- Emergent is authorized by UM clinicians for up to 6 hours per episode. CI- Ongoing is authorized by UM clinicians for up to 66 hours per episode, not to exceed 14 days. An episode is defined as the initial face-to-face contact with the individual until the current crisis is resolved. Requests for more than 6 hours of CI-Emergent and 66 hours and/or 14 days of CI-Ongoing may be authorized with medical director review.

Medical Necessity Criteria

In addition to the LDH Behavioral Health Services Provider Manual, the primary medical necessity criteria used to authorize CI services is 20th Edition MCG Guideline Crisis Intervention Behavioral Health Level of Care ORG: B-905-CI (BHG).

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

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

- **Recommended treatment is necessary, appropriate, and not feasible at lower level of care;**
- **Adequate outcome (eg, stabilization and identification of resources and support for care outside of crisis intervention services) is expected within short time period;**
- **Patient is willing to participate in treatment (or agrees to participate at direction of parent or guardian) within specified intervention and treatment structure voluntarily (or due to court order);**
- **Patient has sufficient ability to respond as planned to individual and group interventions.**

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
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