AETNA BETTER HEALTH®

d/b/a Aetna Better Health of Louisiana

Policy

Policy Name:	Mental Health Intensive Outpatient (MH IOP) Services	Page:	1 of 9
Department:	Medical Management	Policy Number:	7500.75
Subsection:	Prior Authorization	Effective Date:	11/01/2022
Applies to:	■ Medicaid Health Plans		

PURPOSE:

The purpose of this policy is to define Aetna Better Health's ~~business standards~~clinical requirements for the prior authorization of Mental Health Intensive Outpatient (MH IOP) services.

STATEMENT OF OBJECTIVE:

Objectives of the MH IOP services prior authorization process are to:

- Define MH IOP services ~~Accurately document all MH IOP services authorization requests~~
- Ensure the hierarchy of medical necessity criteria for MH IOP is utilized appropriately ~~Verify that a member is eligible to receive MH IOP services at the time of the request and on each date of service~~
- ~~•~~ Establish procedures for reviewing and rendering determination for MH IOP prior authorization requests ~~Assist providers in providing appropriate, timely, and cost-effective MH IOP services~~
- ~~• Verify the practitioner's or provider's network participation~~
- ~~• Define responsibilities of health professionals involved in the medical necessity decision making process~~
- ~~• Evaluate and determine medical necessity and/or need for additional supporting documentation~~
- ~~• Collaborate and communicate as appropriate for the coordination of members' care~~
- ~~• Facilitate timely claims payment by issuing prior authorization numbers to practitioners or providers for submission with claims for approved services~~
- ~~• Place appropriate limits on MH IOP services 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 MH IOP services providers to facilitate SCA's as needed to secure appropriate treatment for members~~
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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 MH IOP services prior authorization process is governed by:

- ~~2020~~ 2023 Louisiana Medicaid Managed Care Organization Statement of Work~~, 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 2021~~
- ~~Policy 7000.30 Process for Approving and Applying Medical Necessity Criteria~~
- Louisiana Department of Health (LDH) Hospital Services Provider Manual, revised 04/05/2022

FOCUS/DISPOSITION:

MH IOP services offer members an alternative level of care to standard outpatient follow-up or admission to a more restrictive level of care in an inpatient psychiatric facility. Members eligible for MH IOP would include those that are at risk for inpatient hospitalization for a psychiatric condition, or members needing a step down from an inpatient hospitalization that is higher level than standard outpatient services. ~~MH IOP services provide a minimum of 3 hours per day of treatment, 3 days a week.~~

~~*Aetna Better Health Responsibilities*~~

~~The chief medical officer (CMO) is responsible for directing and overseeing the Aetna Better Health prior authorization of MH IOP services. 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 2021 UM4 A1
[2] NCQA HP 2021 UM3 A3
[3] 2020 Louisiana Medicaid Managed Care Organization Statement of Work, Section 8.1.13
[4] NCQA HP 2021 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 MH IOP services will be presented to the behavioral health medical director for review. The behavioral health medical director conducting the review will 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 MH IOP services 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 MH IOP services based on a medical necessity review.~~[6]

~~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~~

~~[5] NCQA HP 2021 UM4 A1-2~~
~~[6] NCQA HP 2020 UM4 F1~~

~~and treating practitioners/providers are to be documented in the Aetna Better Health authorization system.[7]~~

~~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.[8]~~

Prior Authorization of MH IOP Services

MH IOP services are covered services for members age 12~~8~~ and up. MH IOP services require prior authorization and can be approved for up to 30 days at a time. Providers must submit sufficient documentation to determine medical necessity. Requests for MH IOP services must include an individualized treatment plan that demonstrates the medical necessity of the number of units and duration requested. Failure to do so may result in a partial or complete denial of coverage for services.

MH IOP is a hospital-based service, so providers must follow the guidelines listed in the LDH Hospital Services Provider Manual (Chapter 25 of the Medicaid Services Manual). All members are seen a minimum of monthly by the licensed mental health provider (LMHP) but are seen more frequently as needed for medication changes or increased symptoms. Services should be provided for a minimum of 6 hours a week of treatment for adolescents and a minimum of 9 hours a week of treatment for adults. Staff working with adolescent members (ages 12-17) must have training specific to that population, incorporate family therapy and age-appropriate evidence based practices into the treatment plan, and allow members to participate in school.

Medical Necessity Criteria

The primary medical necessity criteria used to authorize MH IOP services is 26~~5~~th Edition MCG Guideline Intensive Outpatient Program Behavioral Health Level of Care, Adult (B-901-IOP) or 26th Edition MCG Guideline Intensive Outpatient Program Behavioral Health Level of Care,

~~[7] NCQA HP 2020 UM7 D~~
~~[8] 2020 Louisiana Medicaid Managed Care Organization Statement of Work, Section 8.5.4.1.3.1 and 8.5.4.1.3.2~~

Child or Adolescent (B-902-IOP) . Aetna Better Health requires that a behavioral health disorder is present and appropriate for intensive outpatient program with all of the following:

- Mild to moderately severe Psychiatric, behavioral, or other comorbid conditions for adult
- Mild to moderate dysfunction in daily living for adult

Treatment services available at intensive outpatient program are necessary to meet patient needs and 1 or more of the following:

- Specific condition related to admission diagnosis is present and judged likely to further improve at proposed level of care.
- Specific condition related to admission diagnosis is present and judged likely to deteriorate in absence of treatment at proposed level of care.
- Patient is receiving continuing care (eg, transition of care from more or less intensive level of care).

Situation and expectations are appropriate for intensive outpatient program for adult, as indicated by all of the following:

- Recommended treatment is necessary, appropriate, and not feasible at lower level of care (eg, less intensive level is unavailable or not suitable to patient condition or history).
- Patient is willing to participate in treatment voluntarily.
- Patient has sufficient ability to respond as planned to individual and group therapeutic interventions.
- Biopsychosocial stressors have been assessed and are absent or manageable at proposed level of care (eg, any identified deficits can be managed by program directly or through alternative arrangements)[9].

[9] 25th Edition MCG Guideline Intensive Outpatient Program Behavioral Health Level of Care, Adult (B-901-IOP)

~~***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~~

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Aetna Better Health

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Review/Revision History	
11/01/2022	New Policy
03/2023	Removed unnecessary language: Aetna Better Health Responsibilities and Operating Protocol sections; Updated with 2023 Louisiana Medicaid Managed Care Organization Model Contract reference; Updated purpose, objectives, and references sections for clarity; Add updated LDH language regarding service authorization