AETNA BETTER HEALTH®
d/b/a Aetna Better Health of Louisiana
Policy

Policy Name:	Multi-Systemic Therapy (MST)	Page:	1 of 10
Department:	Medical Management	Policy Number:	7100.33
Subsection:	Prior Authorization	Effective Date:	11/19/2019
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 Multi-Systemic Therapy (MST).

STATEMENT OF OBJECTIVE:

Objectives of the MST prior authorization process are to:

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

LEGAL/CONTRACT REFERENCE:

The MST prior authorization process is governed by:

- **2020 Louisiana Medicaid Managed Care Organization Statement of Work**~~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
- Louisiana Department of Health (LDH) Behavioral Health Services Provider Manual

FOCUS/DISPOSITION:

Multi-systemic therapy provides an intensive home/family and community-based treatment for youth who are at risk of out-of-home placement or who are returning from out-of-home placement. The MST model is based on empirical data and evidence-based interventions that target specific behaviors with individualized behavioral interventions. Services are primarily provided in the home, but workers also intervene at school and in other community settings. All MST services must be provided to, or directed exclusively toward, the treatment of the Medicaid-eligible youth[1].

Aetna Better Health Responsibilities

The chief medical officer (CMO) is responsible for directing and overseeing the Aetna Better Health prior authorization of MST 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[2].~~3~~ 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.

[1] **LDH Behavioral Health Services Provider Manual, Appendix E-4: Evidenced Based Practices (EBPs) Policy- Multi-Systemic Therapy, page 1**
[2] NCQA HP **2020** UM4 A1
~~[3] NCQA HP 2020 2018/2019 UM4 A1~~

When initiating or returning calls regarding UM issues, Aetna Better Health requires UM staff to identify themselves by name, title, and organization name;[4] 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.[5~~6~~]

Nonclinical staff is responsible for:[7]

- 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:[8]

- 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

[4] NCQA HP **2020** ~~2018/2019~~ UM3 A3
[5] **2020 Louisiana Medicaid Managed Care Organization Statement of Work**, Section 8.1.13
~~NCQA HP 2018/2019 UM3 A3~~
~~2020 Louisiana Medicaid Managed Care Organization Statement of Work~~~~RFP # 305PUR-LDHRFP-BH-MCO-2014-MVA, Section 8.1.13~~
[7] NCQA HP **2020** ~~2018/2019~~ UM4 A2
[8] NCQA HP **2020** ~~2018/2019~~ UM4 A1-2

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 MST based on a medical necessity review.[9]

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.[10] 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.[11]

[9] NCQA HP **2020** ~~2018/2019~~ UM4 F1
[10] NCQA HP **2020** ~~2018/2019~~ UM4 A2
[11] NCQA HP **2020** ~~2018/2019~~ UM7 D

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.[12]

Medical Necessity Criteria

Multi-Systemic Therapy (MST) requires prior authorization. The primary medical necessity criteria used to authorize MST is the LDH Behavioral Health Services Provider Manual, Appendix E-4: Evidenced Based Practices (EBPs) Policy- Multi-Systemic Therapy. MST services are targeted for youth primarily demonstrating externalizing behaviors, such as conduct disorder, antisocial or illegal behavior or acts that lead to costly and, oftentimes, ineffective out-of-home services or excessive use of child-focused therapeutic support services. Depression and other disorders are considered, as long as the existing mental and behavioral health (BH) issues manifest in outward behaviors that impact multiple systems (i.e., family, school, community). Youth with substance use issues may be included if they meet the criteria below, and MST is deemed clinically more appropriate than focused drug and alcohol treatment. The following criteria must be meet for MST services:

- Referral/target ages of 12-17 years;
- Youth exhibits significant externalizing behavior, such as chronic or violent juvenile offenses;
- Child is at risk for out-of-home placement or is transitioning back from an out-of-home setting;
- Externalizing behaviors symptomatology, resulting in a DSM-5 or ICD-10 diagnosis of conduct disorder or other diagnoses consistent with such symptomatology (oppositional defiant disorder, other disruptive, impulse-control, and conduct disorders, etc.);
- Ongoing multiple system involvement due to high risk behaviors and/or risk of failure in mainstream school settings due to behavioral problems;
- Less intensive treatment has been ineffective or is inappropriate; or
- The youth's treatment planning team or CFT recommends that he/she participate in MST.

[12] **2020 Louisiana Medicaid Managed Care Organization Statement of Work**~~RFP # 305PUR-LDHRFP-BH-MCO-2014-MVA~~, Section 8.5.4.1.3.1 and 8.5.4.1.3.2

MST services may not be clinically appropriate for individuals who meet the following conditions:

- Youth referred primarily due to concerns related to suicidal, homicidal or psychotic behavior;
- Youth living independently, or youth whom a primary caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends or other potential surrogate caregivers;
- The referral problem is limited to sexual offending in the absence of other delinquent or antisocial behavior;
- Youth with moderate to severe difficulties with social communication, social interaction, and repetitive behaviors, which may be captured by a diagnosis of autism;
- Low-level need cases or
- Youth who have previously received MST services or other intensive family- and community-based treatment.

Exception: Youth may be allowed an additional course of treatment if all of the following criteria are met:

- MST program eligibility criteria are currently met;
- Specific conditions have been identified that have changed in the youth's ecology, compared to the first course of treatment;
- It is reasonably expected that successful outcomes could be obtained with a second course of treatment; and
- Program entrance is subject to prior authorization by Aetna Better Health.

Individuals receiving MST services must meet all of the following criteria for continuing treatment with MST:

- Treatment does not require more intensive level of care.
- The treatment plan has been developed, implemented and updated based on the youth's clinical condition and response to treatment, as well as the strengths of the family, with realistic goals and objectives clearly stated.
- Progress is clearly evident in objective terms, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address the lack of progress are evident.

- The family is actively involved in treatment, or there are active, persistent efforts being made which are expected to lead to engagement in treatment.

Individuals who meet the following criteria no longer meet medical necessity criteria for MST and should be discharged from MST treatment:

- The recipient's treatment plan goals or objectives have been substantially met.
- The recipient meets criteria for a higher or lower level of treatment, care or services.
- The recipient, family, guardian and/or custodian are not engaging in treatment or not following program rules and regulations, despite attempts to address barriers to treatment.
- Consent for treatment has been withdrawn, or youth and/or family have not benefitted from MST, despite documented efforts to engage, and there is no reasonable expectation of progress at this level of care, despite treatment.

Exclusions

MST services are comprehensive of all other services, with the exception of psychological evaluation or assessment and medication management. These services may be provided and billed separately for a recipient receiving MST services. MST should not be billed in conjunction with the following services:

- BH services by licensed and unlicensed individuals, other than medication management and assessment.
- Residential services, including professional resource family care[13].

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.

[13] **LDH Behavioral Health Services Provider Manual, Appendix E-4: Evidenced Based Practices (EBPs) Policy- Multi-Systemic Therapy, pages 1-4, 14**

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
Chief Medical Officer

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Review/Revision History	
10/2020	Added additional language from Aetna Better Health of Louisiana Prior Authorization policy, updated contract and NCQA references, added a reference for language included from the LDH Behavioral Health Services manual