

Clinical Policy: Mental Health Rehab Medical Necessity Criteria (MNC) Policy for Community Psychiatric Support and Treatment (CPST) and Psycho-social Rehab (PSR)

Reference Number: LA.CP.MP.90

Last Review Date: 6/20

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

To establish the process and mechanism for determining authorization requests for Mental Health Rehabilitation (MHR) services which includes Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR) services for Louisiana Healthcare Connections members.

Policy/Criteria

Louisiana Healthcare Connections will determine if services are medically necessary based upon the clinical information supplied by the treating provider, including assessments, CALOCUS/LOCUS, treatment plan, Outpatient Treatment Request (OTR) form, and supplemental information

Rehabilitation services are provided as part of a comprehensive specialized psychiatric program available to all Medicaid eligible children, adolescents and adults with significant functional impairments resulting from an identified mental health disorder diagnosis. The medical necessity for these rehabilitative services must be determined by and services recommended by a licensed mental health professional (LMHP) or physician.

I. Children and Adolescents

The expected outcome of rehabilitation services is restoration to a child/adolescent's best level of functioning by restoring the child/adolescent to their best developmental trajectory. This includes consideration of key developmental needs and protective factors such as:

- Restoration of positive family/caregiver relationships;
- Prosocial peer relationships;
- Community connectedness/social belonging; and
- The ability to function in a developmentally appropriate home, school, vocational and community settings.

Services should provide skills building and supports that build on existing strengths and target goals related to these key developmental needs and protective factors.

II. Adults

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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 home and community-based and are provided on an as needed basis to assist persons in coping with the symptoms of their illness. In order to meet the criteria for disability, one must exhibit impaired emotional, cognitive or behavioral functioning that is a result of mental illness. The impairment must substantially interfere with role, occupational and social functioning.

Rehabilitation services are expected to achieve the following outcomes:

- Assist individuals in the stabilization of acute symptoms of illness
- Assist individuals in coping with chronic symptoms of their illness;
- Minimize the aspects of their illness which makes it difficult for persons to live independently;
- Reduce or prevent psychiatric hospitalizations;
- Identify and develop strengths; and
- Focus on recovery (see LDH Behavioral Health Provider Manual section 2.3 Outpatient Services)

Background

PROCEDURE:

Prior Authorization Process

- A. The Plan requires the following documentation to be submitted by the provider when requesting initial MHR services:
- Outpatient Treatment Request (OTR) form
 - CALOCUS/LOCUS (appropriate to the member's age)
 - CALOCUS – Members ages 6 – 18
 - LOCUS – Members ages 19 and older
 - Annual assessment completed by a Licensed Mental Health Professional- LMHP (Bayou Health Behavioral Health Assessment – for adults) –please note this is only due annually or as needed any time there is a significant change to the member's circumstance
 - Preliminary Treatment Goals identified by CALOCUS/LOCUS assessment needs
 - Homebuilders approval, if applicable
 - Additional supporting documentation, if applicable
 - Member Freedom of Choice Form
 - Members may only receive mental health rehabilitation services from one provider at a time with the following exceptions:
 - A member is receiving tenancy support through the Permanent Supportive Housing Program, and/or
 - The Plan's Behavioral Health Medical Advisor makes the determination that it is medically necessary and clinically appropriate to receive services from more than one MHR provider (and all requirements in the LDH Behavioral Health Provider Manual are met).

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- The submission of a new authorization request with a member freedom of choice form will result in discontinuation of the current MHR authorization from the previous provider unless the above exceptions are met.
- B. The Plan requires the following documentation to be submitted by the provider when requesting continuation of MHR services:
- OTR form
 - CALOCUS/LOCUS (appropriate to the member's age)
 - Comprehensive Treatment Plan with SMART goals signed by all required parties and a copy given to the member/guardian
 - Specific
 - Measurable
 - Achievable
 - Realistic
 - Time-oriented
 -
 - Homebuilders approval, if applicable
 - Additional supporting documentation, if applicable, indicating:
 - Member's progress or lack of progress in treatment,
 - Interventions that have or have not worked to improve member's presentation
 - Current symptoms and how they impact the member's current functioning
- C. Treatment Plans will be updated every 180 days based upon assessment needs from CALOCUS/LOCUS for all members
- The LMHP must review the treatment plan including the goals, objectives, interventions, places of service, and service participants to ensure each service contact increases the possibility that a member will make progress. To determine if updates are needed, the review must be in consultation with provider staff, the member/caregiver and other stakeholders at least once every 180 days or more often if indicated. The member record must include documentation of the treatment plan review.
 - The member shall receive a signed copy of the plan upon completion and after each revision. A copy of the treatment plan should also be sent to all of the individuals involved in implementing and monitoring the treatment plan. The treatment plan should not include services that are duplicative, unnecessary or inappropriate
- D. Request for services will be authorized for up to 60 days of services at a time.
- E. The Plan encourages and promotes the use of evidenced-based practices (EBP).
- If a member is identified as potentially being able to benefit from and meeting medical necessity criteria for evidence based treatment, and EBPs are available to the recipient, the Plan will deny the CPST/PSR services and will authorize the identified

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- EBP (more appropriate level of care) through the same agency or facilitate recipient transfer to an available provider who can meet the needs of the member.
- If a member is identified as potentially being able to benefit from an evidence based treatment but unable to access EBPs, the Plan will approve the CPST/PSR services when the MHR provider's documentation includes all of the following:
 - A pre and post evaluation of treatment with each authorization request
 - The utilization of a standard and consistent tool to evaluate progress toward treatment goals
 - If the member is demonstrating progress toward goals without EBP, the Plan will continue authorizing the requested services through the established authorization process.
 - If the member fails to progress after a reasonable timeframe, the Medical Advisor will review the clinical documentation, and offer a peer to peer discussion, and will then render a determination based upon all of the available clinical information. An adverse determination letter will be sent to the member and provider communicating the decision of a full or partial denial to the provider along with a recommendation for a more appropriate level of care if needed.
 - The Plan's policy does not require the authorization of services that are not evidence based, however, if a reasonable non-EBP is proposed, along with an acceptable plan of care and goals, it may be authorized at the discretion of the Plan's Medical Advisor if there is an indication that the member may receive some benefit (if not the optimal benefit) from the service.
- F. The Plan allows for reasonable coverage of services at one level of care while providers are working with the Plan's Utilization Management team to transition a member to the next level of care. For MHR, continued services will be allowed for a minimum of 1 week and up to a maximum of 2 weeks (at the discretion of the Plan Medical Advisor) to allow for the appropriate transition to the next level of care. The Adverse Determination letter will also indicate the specific reason for the denial and the timeframe allowed for the transition of care as specified in LA.UM.07 *Adverse Determination (Denial) Notices*.

Medical Necessity Criteria

All mental health rehabilitation services must be medically necessary and are subject to prior authorization. The medical necessity for these rehabilitative services must be determined by, and recommended by, an LMHP or physician to promote the maximum reduction of symptoms and/or restoration of an individual to his/her best age-appropriate functional level.

Community Psychiatric Support and Treatment (CPST)

CPST is a comprehensive service which focuses on reducing the disability resulting from mental illness, restoring functional skills of daily living, building natural supports and solution-oriented interventions intended to achieve identified goals or objectives as set forth in the individualized treatment plan. CPST is a face-to-face intervention with the individual present; however family or other collaterals may be involved. Most contacts occur in community locations where the person lives, works, attends school and/or socializes.

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The specific requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission – Severity of Need

Criteria A, B, and C must be met:

- A. The member is unable to maintain an adequate level of functioning without this service due to a Psychiatric disorder as evidenced by (must meet 1 and either 2 or 3):
 - 1) Severe symptoms and/or history of severe symptoms for a significant duration, and
 - 2) Impairment in performance of the activities of daily living, and/or
 - 3) Significant disability of functioning in at least one major life area including social, occupational, living and/or learning.
- B. The member seeks and actively participates in a joint provider/member assessment and the provider/member jointly agree that the member desires, is committed to, and will likely benefit from the supportive/rehabilitation process. Documentation of member assessment and demonstration of potential member benefit will be sufficient when there is evidence that provider is working on member engagement.
- C. The interventions necessary to stabilize, the member's behaviors, symptoms, and ability to function related to their psychiatric disorder requires the frequency, intensity and duration of contact provided by the CPST provider as evidenced by:
 - 1) Failure to stabilize, progress, or improve functioning with a less intensive intervention, and/or
 - 2) Need for specialized intervention for a specific impairment or disorder.
- D. Adults must meet the Substance Abuse and Mental Health Services Administration (SAMHSA) definition of, serious mental illness (SMI) as evidenced by a rating of three or greater on the functional status domain and at least a level of care score of three on the Level of Care Utilization System (LOCUS) rating. In addition to having a diagnosable mental disorder, the condition must substantially interfere with, or limit, one or more major life activities, such as:
 - 1) Basic daily living (for example, eating or dressing);
 - 2) Instrumental living (for example, taking prescribed medications or getting around the community); and
 - 3) Participating in a family, school, or workplace

II. Admission – Intensity and Quality of Service

Criteria A, B, C, D, E and F must be met

- A. Assist the individual and family members or other collaterals to identify strategies or treatment options associated with the individual's mental illness, with the goal of

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minimizing the negative effects of Mental Health emotional disturbances or associated environmental stressors which interfere with the individual's daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships and community integration.

- B. Provide individual supportive counseling, solution-focused interventions, emotional and behavioral management and problem behavior analysis to the individual, with the goal of assisting the individual with developing and implementing social, interpersonal, self-care, daily living and independent living skills to restore stability, to support functional gains and to adapt to community living.
- C. Participation in and utilization of, strengths-based planning and treatments, which include assisting the individual and family members or other collaterals with identifying strengths and needs, resources, natural supports and developing goals and objectives to utilize personal strengths, resources and natural supports to address functional deficits associated with their mental illness.
- D. Assist the individual with effectively responding to or avoiding identified precursors or triggers that would risk him or her remaining in a natural community location, including assisting the individual and family members or other collaterals with identifying a potential psychiatric or personal crisis, developing a crisis management plan and/or, as appropriate, seeking other supports to restore stability and functioning.
- E. Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the youth's medical record. The provider shall participate in Team meetings and/or conferences with other child-serving entities (i.e.; DCFS, OCDD, CSoC, MCO, Juvenile Justice System, etc.)
- F. The provider shall make every effort to participate in regularly scheduled Child and Family Team meetings with the child/youth and family/natural supports as best practice.

III. Continued Stay

Criteria A, B, C and D must be met:

- A. The member continues to meet admission criteria.
 - 1) An adult 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 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
- B. Recovery requires a continuation of these services.

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- C. Member, and family (when available and included in the treatment plan) are making progress toward goals and actively participating in the interventions. In the instance of limited or no progress, there must be documented evidence of changes in the treatment plan, efforts to engage the member and/or family, or some other action to address the lack of progress.
- D. There is a reasonable likelihood of continued substantial benefit as a result of active continuation of the services, as demonstrated by objective behavioral/functional measurements of improvement.

Psychosocial Rehabilitation (PSR)

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. Activities included must be intended to achieve the identified goals or objectives as set forth in the individual's individualized treatment plan. The intent of PSR is to restore the fullest possible integration of the individual as an active and productive member of his or her family, community and/or culture with the least amount of ongoing professional intervention. PSR is a face-to-face intervention with the individual present. Services may be provided individually or in a group setting. Most contacts occur in community locations where the person lives, works, attends school and/or socializes.

The specific requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission – Severity of Need

Criteria A, B, and C must be met:

- A. Diagnosable mental health disorder that the condition must substantially interfere with the role, occupational and social functioning. The level of functioning without this service due to a psychiatric disorder as evidenced by (must meet 1 and either 2 or 3):
 - 1) Severe symptoms and/or history of severe symptoms for a significant duration, and
 - 2) Impairment in performance of the activities of daily living, and/or
 - 3) Significant disability of functioning in at least one major life area including social, occupational, living and/or learning.
- B. The member seeks and actively participates in a joint provider/member assessment and the provider/member jointly agree that the member desires, is committed to, will likely benefit from the rehabilitation process.
- C. The interventions necessary to stabilize the member's behaviors, symptoms, and ability to function related to their psychiatric disorder requires the frequency, intensity and duration of contact provided by the rehabilitative service as evidenced by:
 - 1) Failure to reverse/stabilize/progress with a less intensive intervention, and/or
 - 2) Need for specialized intervention for a specific impairment or disorder.

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- D. Adults must meet the Substance Abuse and Mental Health Services Administration (SAMHSA) definition of, serious mental illness (SMI) as evidenced by a rating of three or greater on the functional status domain and at least a level of care score of three on the Level of Care Utilization System (LOCUS) rating. In addition to having a diagnosable mental disorder, the condition must substantially interfere with, or limit, one or more major life activities, such as:
- 1) Basic daily living (for example, eating or dressing);
 - 2) Instrumental living (for example, taking prescribed medications or getting around the community); and
 - 3) Participating in a family, school, or workplace

II. Admission – Intensity and Quality of Service

Criteria A through F must be met.

- A. Services are to develop social and interpersonal skills to increase community tenure, enhance personal relationships, establish support networks, increase community awareness, develop coping strategies and effective functioning in the individual's social environment, including home, work and school.
- B. Services are to develop daily living skills to improve self-management of the negative effects of psychiatric or emotional symptoms that interfere with a person's daily living. Supporting the individual with development and implementation of daily living skills and daily routines necessary to remain in home, school, work and community.
- C. Services restore learned skills so the person can remain in a natural community location and achieve developmentally appropriate functioning.
- D. Services are to assist the individual with effectively responding to or avoiding identified precursors or triggers that result in functional impairments.
- E. Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the youth's medical record.
- F. The provider shall make every effort to participate in any regularly scheduled Team meetings and/or conferences with other child-serving entities (i.e.; DCFS, OCDD, CSoC, MCO, Juvenile Justice System, etc.) and with the child/youth and family/natural supports as best practice.

III. Criteria for Continued Stay

Criteria A, B and C must be met.

- A. An assessment appropriate to the recovery model indicates at least one of the following:

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- 1) As a result of the psychiatric diagnosis, there are or continue to be functional impairments and skill deficits which are effectively addressed in the individualized treatment plan. In the event that earlier efforts have not achieved the intended objectives, the revised plan indicates service modifications to address these issues, or
 - 2) There is a reasonable expectation that the withdrawal of services may result in loss of rehabilitation gains or goals attained by the member, or
 - 3) It has been identified that the member requires a different level of care or service and additional time is needed with the current mental health provider to effectively implement a transition plan to ensure continuity of care.
- B. The reasonable likelihood of substantial benefit as a result of active continuation of the services, as demonstrated by objective behavioral/functional measurements of improvement.
- C. The member/family chooses to continue in the program.

Limitations/Exclusions

- Any adult with a diagnosis of substance use disorder or intellectual/developmental disability without an additional co-occurring qualifying mental health diagnosis.
- Components that are not provided to, or directed exclusively toward, the treatment of the Medicaid eligible individual.
- Services provided at a work site which are job tasks oriented and not directly related to the treatment of the member’s needs.
- These rehabilitation services shall not duplicate any other Medicaid State Plan service or service otherwise available to the member at no cost.
- Any services or components in which the basic nature of which are to supplant housekeeping, homemaking, or basic services for the convenience of an individual receiving services.

Reviews, Revisions, and Approvals	Date	Approval Date
Original approval date		
<ul style="list-style-type: none"> • Service Delivery Section: added LDH update • Assessment and Treatment Planning Section: added LDH updates regarding CA/LOCUS and CA/LOUCS manual language regarding when additional assessments are needed. • Prior Authorization process section B: added clarification of what additional information is required for auth requests. • Prior Authorization process section C: Removed allowance of a request over the 60 day standard auth period as MHR auths are only given for 60 days. • Removed UM Staff and replaced with Adverse Determination Letter in Prior Auth Section D and E. 	5/19	

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Reviews, Revisions, and Approvals	Date	Approval Date
<ul style="list-style-type: none"> • Updated scope to include Louisiana Healthcare Connections • Grammatical changes • Formatting changes • Removed language that is located in the LDH BH Provider Manual • Changed LHCC to The Plan • Updated Prior Auth process • Changed Medical Director to Medical Advisor • Added Goals of PSR • Updated references 	4/20	
<ul style="list-style-type: none"> • Removed promoting maximum reduction of symptoms • Changed Section 2.3 Outpatient for National Consensus Statement on Recovery to 2.3 Outpatient Services • Moved Locus score of 2 down to MNC criteria • Changed services teach to services restore learned skills • Changed psychiatric rehabilitation plan to individualized treatment plan • Add Adult MNC Criteria • Updated Treatment plan information as changes were made to LDH provider manual 	6/20	

References

1. Louisiana Department of Health Behavioral Health Services Provider Manual
2. Louisiana Behavioral Health Partnership Service Definitions Manual Version 7
3. LA.UM.07Adverse Determination (Denial) Notices

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, Centene's P&P management software, is considered equivalent to a physical signature.

Sr. VP, Population Health: Electronic Signature on File
Chief Medical Officer:-Electronic Signature on File

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing

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this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. LHCC retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom LHCC has no control or right of control. Providers are not agents or employees of LHCC.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs,

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and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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