AETNA BETTER HEALTH®

d/b/a Aetna Better Health of Louisiana

Policy

Policy Name:	Peer Support Services	Page:	1 of 8
Department:	Medical Management	Policy Number:	7000.13
Subsection:	Prior Authorization	Effective Date:	01/20/2022
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 Peer Support Services.

STATEMENT OF OBJECTIVE:

Objectives of the Peer Support Services prior authorization process are to:

- Accurately document all Peer Support Services authorization requests
- Verify that a member is eligible to receive Peer Support Services at the time of the request and on each date of service
- Assist providers in providing appropriate, timely, and cost-effective Peer Support 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 Peer Support 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 Peer Support Services 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 Peer Supports Services prior authorization process is governed by:

- 2020 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 2020
- Policy 7000.30 Process for Approving and Applying Medical Necessity Criteria
- Louisiana Department of Health (LDH) Behavioral Health Services Provider Manual

FOCUS/DISPOSITION:

Peer Support Services are an evidence-based behavioral health service that consists of a qualified peer support provider, who assists members with their recovery from mental illness and/or substance use. Peer Support Services are provided by Office of Behavioral Health Recognized Peer Support Specialists, who are individuals with personal lived experience with recovery from behavioral health conditions and successfully navigating the behavioral health services system. Peer Support Services are behavioral health rehabilitative services to reduce the disabling effects of an illness or disability and restore the member to the best possible functional level in the community. Peer Support Services are person-centered and recovery focused. Peer Support Services are face-to-face interventions with the member present. Most contacts occur in community locations where the member lives, works, attends school and/or socializes[1].

Aetna Better Health Responsibilities

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

[1] LDH Behavioral Health Services Provider Manual, Section 2.3: Outpatient Services – Peer Support Services, page 1

qualified by training, experience and certification/licensure to conduct the utilization management (UM) functions in accordance with state and federal regulations.[2] 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;[3] 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.[4]

Nonclinical staff is responsible for:[5]

- 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:[6]

- 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:

[2] NCQA HP 2021 UM4 A1
[3] NCQA HP 2021 UM3 A3
[4] 2020 Louisiana Medicaid Managed Care Organization Statement of Work, Section 8.1.13
[5] NCQA HP 2021 UM4 A2
[6] NCQA HP 2021 UM4 A1-2

- 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 Peer Support 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 Peer Support 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 Peer Support Services based on a medical necessity review.[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]

[7] NCQA HP 2021 UM4 F1
[8] NCQA HP 2020 UM7 D
[9] 2020 Louisiana Medicaid Managed Care Organization Statement of Work, Section 8.5.4.1.3.1 and 8.5.4.1.3.2

Prior Authorization of Peer Support Services

Peer Support Services requires prior authorization. Providers must submit sufficient documentation to determine medical necessity. Requests for peer support services must include an individualized treatment plan that demonstrates the medical necessity of the number of units and duration requested and how those units will be utilized. Failure to do so may result in a partial or complete denial of coverage for services. Services may be provided at a facility or in the community as outlined in the treatment plan.

Medical Necessity Criteria

In addition to the LDH Behavioral Health Services Provider Manual, the primary medical necessity criteria used to authorize Peer Support Services is 25th Edition MCG Peer Support Services ORG: B-810-T (BHG). Members who meet medical necessity criteria may receive Peer Support Services when recommended by an LMHP or physician within their scope of practice. Members must be 21 years of age or older and have a mental illness and/or substance use disorder diagnosis.

Aetna Better Health requires that a behavioral health disorder is present and appropriate for peer support services with all of the following:

- Moderate Psychiatric, behavioral, or other comorbid conditions
- Moderate dysfunction in daily living
- Situation and expectations are appropriate for peer support services as indicated by all of the following:
    - Recommended treatment is necessary and not appropriate for less intensive care (ie, patient requires assistance in accessing services; and documented behavior, symptoms, or risk is inappropriate for outpatient office care or traditional case management)
    - Patient is assessed as not at risk of imminent danger to self or others
    - Current primary treatments (eg, pharmacotherapy, psychosocial therapy) have been insufficient to meet care needs
    - Targeted symptoms, behaviors, and functional impairments related to underlying behavioral health disorder have been identified and are appropriate for peer support services

- Treatment plan addresses biopsychosocial stressors and includes coordination of care with other providers and community-based resources as appropriate
- Treatment plan includes explicit and measurable recovery goals that will define patient improvement, with regular assessment that progress toward goals is occurring or that condition would deteriorate in absence of continued peer support services
- Treatment plan engages family, caregivers, and other people impacted by and in position to affect patient behavior, as appropriate
- Treatment intensity (i.e., number of hours per week) and duration is individualized and designed to meet needs of patient, and will be adjusted according to patient's response to treatment and ability to participate effectively
- Patient is expected to be able to adequately participate in and respond as planned to proposed treatment.

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

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