To: **AmeriHealth Caritas Louisiana Behavioral Health Providers**

Date: **February 29, 2016**

Subject: **Prior Authorizations for Community Psychiatric Supportive Treatment (CPST)**

Summary: AmeriHealth Caritas Louisiana is providing information to facilitate prior authorization requests for Community Psychiatric Supportive Treatment (CPST). This communication gives providers guidance on filling out the ACLA Child & Adolescent Mental Health Rehabilitation Treatment Form for Community Psychiatric Supportive Treatment (CPST). It also provides a crosswalk between the 2012 Louisiana Behavioral Health Partnership Service Authorization Criteria and the questions on the form for both initial and continued stay authorization requests.

AmeriHealth Caritas Louisiana is providing information to facilitate prior authorization requests for Community Psychiatric Supportive Treatment (CPST). To request a prior authorization, fill out the ACLA Child & Adolescent Mental Health Rehabilitation Treatment Form, located on the AmeriHealth Caritas Louisiana website at: http://amerihealthcaritasla.com/provider/resources/forms/index.aspx

AmeriHealth Caritas Louisiana's medical necessity reviews are consistent with the 2012 Louisiana Behavioral Health Partnership (LBHP) Service Authorization Criteria. The LBHP Admission Criteria and Continued Stay Criteria are listed in two tables below. For each criterion, the associated question on the ACLA form is listed.

In addition to answering the questions on the form**, the clinical assessment and/or the treatment plan should be provided to support the responses**.

Initial Request

2012 Louisiana Behavioral Health Partnership Service Authorization Admission Criteria	**Question Number on the ACLA Child & Adolescent Mental Health Rehabilitation Treatment Form**
The member is unable to maintain an adequate level of functioning without this service due to a mental health disorder as evidenced by:	
1. Inadequate level of functioning	#1. The member is unable to be managed at a less intensive level of care safely within the last week. Need to denote specific behaviors or symptoms or if lower level (therapy, med mgmt., school services, etc.) have been attempted, please indicate in the clinical assessment and/or treatment plan.
2. Severe symptoms and/or history of severe symptoms for a significant duration	#3. The member has displayed any of the following within the last week (check all that apply). (See form for complete list.)
3. Significant duration	#4. Have the behaviors been persistent for at least 6 months? (Yes or No) AND #5. Are the behaviors expected to continue longer than 1 year without treatment? (Yes or No)
4. Inability to perform the activity of daily living and significant disability of functioning in at least one major life area including social, occupational, living and/or learning.	#9. The member has severe impairment in the below (check all that apply). (See form for complete list.)
5. 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 supportive/rehabilitation process.	N/A to the form. Document in the clinical assessment and/or treatment plan.
6. The interventions necessary to reverse, stabilize or enhance the member's condition requires the frequency, intensity and duration of contact provided by the CPST provider as evidenced by failure to reverse/stabilize/progress with less intensive intervention.	#2. Is the member currently in short-term respite or any other mental health/substance use disorder services? (Yes or No) AND/OR #6. The member has had unsuccessful treatment history in any of the following within the last 6-12 months (check all that apply). (See form for complete list.
7. Need for specialized intervention for a specific impairment or disability.	#7. The member's support system is any of the following within the last 6-12 months (check all that apply). (See form for complete list.) AND #8. The member's living environment: please check one. (See form for complete list.)

Continued Stay Requests

2012 Louisiana Behavioral Health Partnership Service Authorization Continued Stay Criteria	Question Number in the Continued Stay Section on the ACLA Child & Adolescent Mental Health Rehabilitation Treatment Form
1. The member continues to meet admission criteria.	#1. Within the last month, the member has experienced and/or displayed the following (check all that apply). (See form for complete list.)
2. Recovery requires a continuation of these services.	N/A to the form. Document in the clinical assessment and/or treatment plan.
3. Member, and family as appropriate, are making progress toward goals and actively participating in the interventions.	N/A to the form. Document in the clinical assessment and/or treatment plan.
4. 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.	#2. The member is receiving the following services: (See form for complete list.)

Thank you for your continued support and commitment to the care of our members. If you have questions about this communication, please contact AmeriHealth Caritas Louisiana's Provider Services department at 1-888-922-0007 or your Provider Network Management Account Executive.