Medical Necessity Guideline

Medical Necessity Guideline (MNG) Title: Community Support Programs		
MNG #: 026	**☒SCO ☒One Care**	**Prior Authorization Needed? ☐Yes ☒No**
Clinical: ☒	**Operational: ☐**	**Informational: ☐**
Medicare Benefit: ☒Yes ☒No	**Approval Date:** 9/12/2019;	**Effective Date:** 1/01/2020;
Last Revised Date: 5/5/2020;	**Next Annual Review Date:** 9/12/2020; 05/05/2021;	**Retire Date:**

OVERVIEW:

Community Support Programs, which are often delivered by paraprofessionals, provide community based intensive case management services to members who are at risk for readmission or admission to at a 24-hour psychiatric or substance abuse facility. Services are offered in the community, at home or in a non-clinical facility. Community Support Providers (CSPs) may accompany members to medical or behavioral health appointments. CSPs' connect members to essential community resources. Community Support Programs also include outreach and engagement activities to facilitate face to face interactions with members. CSP workers are expected to collaborate with the Interdisciplinary Care Team (ICT). The intensity and level of support provided is based on the individual needs of the member.

CSP Provides:

- Urgent coverage for members 24 hours a day, with referrals to Emergency Service Providers (ESPs) as needed.
- Services in the home in safe environments.
- Collaboration with Behavioral Health (BH) Providers and ICT.
- Symptom Management.
- Crisis Intervention.

Crisis Intervention Goals for the CSP Include:

- Reducing recidivism rates for inpatient and/or ER visits.
- Reducing Psychotic episodes.
- Addressing co-occurring mental health and substance abuse.
- Addressing health complications.
- Decreasing suicidality / homicidally rates.

With the participation of the member and multidisciplinary team, a treatment plan is developed. Ongoing documentation is collected to evaluate effectiveness.

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DECISION GUIDELINES:

Clinical Eligibility:

- Member has a Psychiatric diagnosis or Substance Abuse diagnosis.
- Member is experiencing an acute life crisis or has severe escalation in symptoms that has disrupted his/her daily level of functioning and needs additional support.
- Member is not at risk to harm himself/herself or others and does not require 24-hour medical or psychiatric supervision.
- Member has active stable community supports when not in program (e.g., family, care giver, social service supports).
- Member may be stepping down from a more intensive level of support (i.e., inpatient, PHP, IOP, and Crisis Stabilization Unit).
- Services must be provided in accordance with the member's goals as stated in the care plan.

Determination of Medical Necessity:

- Member has been assessed and will benefit from intensive community-based services.
- Services may be used for individuals with physical, mental, and/or cognitive impairments who are unable to safely or effectively perform an activity and for whom such services will support his/her improved health status and his/her ability to maintain integrated living in the community.

LIMITATIONS/EXCLUSIONS:

CCA will collaborate with ICT and CSP when considering a Discharge Plan.

KEY CARE PLANNING CONSIDERATIONS:

- . CCA may share information as appropriate to help providers/facility understand the member's history, current treatment, and treatment needs.
- Evaluation of informal supports to provide the service should be considered (e.g., family member or friend).
- A review of other existing supports in the care plan should be conducted before initiating new services to prevent against duplicative services.
- Members experiencing an emotional or mental health diagnosis that prevents him/her from safely preforming this task, may be eligible for these services based on the team's assessment.

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AUTHORIZATION:

Prior authorization is not required.

Disclaimer:

This Medical Necessity Guideline is not a rigid rule. As with all of CCA's criteria, the fact that a member does not meet these criteria does not, in and of itself, indicate that no coverage can be issued for these services. Providers are advised, however, that if they request services for any member who they know does not meet our criteria, the request should be accompanied by clear and convincing documentation of medical necessity. The preferred type of documentation is the letter of medical necessity, indicating that a request should be covered either because there is supporting science indicating medical necessity (supporting literature (full text preferred) should be attached to the request), or describing the member's unique clinical circumstances, and describing why this service or supply will be more effective and/or less costly than another service which would otherwise be covered. Note that both supporting scientific evidence and a description of the member's unique clinical circumstances will generally be required.

RELATED REFERENCES:

1. Centers for Medicaid and Medicare Services, National Coverage Determination (NCD) 130.6, Medicare Benefit Policy Manual: Chapter 2, 6, and 15.
2. MassHealth Provider Manual; 130 CMR 429.000 – 429.441.

ATTACHMENTS:

EXHIBIT A:	
EXHIBIT B:	

REVISION LOG:

REVISION DATE	DESCRIPTION
9/12/2019	Reviewed and approved by Medical Policy Committee.
5/5/2020	Update documents according to Sarah Parsons and Livia Ataide comments

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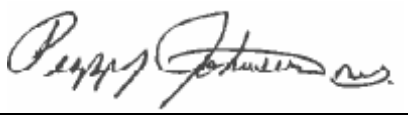
APPROVALS:

Peggy L. Johnson, MD	Vice President and Chief of Psychiatry
CCA Senior Clinical Lead [Print]	**Title [Print]**
	9/12/2019
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