



Level of Care Assessment Tool

GENERAL GUIDELINES

Introduction

This Level of Care Assessment Tool (LOCAT) was developed to provide guidelines for evaluating the medical necessity of care for mental health disorders. The LOCAT is not the guideline for substance-related and addictive disorders but may be used in conjunction with such guidelines when there is a presentation of multiple diagnoses that include both Mental Health and Addictive Disorders. LOCAT is not a replacement for good clinical judgment, which should be exercised both in connection with applying the LOCAT guidelines as described below and more broadly in assessing the medical necessity of particular levels of treatment in light of the specific condition for which the member is seeking treatment. Moreover, the benefits available to a covered person are based solely on the terms of the person's plan of benefits, which governs all coverage decisions.

Aetna uses LOCAT to help determine whether a level of care is **medically necessary**. The term **medically necessary** is defined in each individual's health plan documents, and the definition in those plan documents governs the medical necessity determination. As a general guideline, medically necessary services are those services that are appropriate and consistent with the diagnosis in accordance with accepted medical standards. To be medically necessary, the service or supply must, at a minimum:

- Be care or treatment as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, as to both the disease or injury involved and your overall health condition;
- Be care or services related to diagnosis or treatment of an existing illness or injury, except for covered periodic health evaluations and preventive and well-baby care, as determined by Aetna;
- Be a diagnostic procedure, indicated by the health status of the Plan participant, and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, as to both the disease or injury involved and your overall health condition;
- Include only those services and supplies that cannot be safely and satisfactorily provided at home, in a physician's office, on an outpatient basis, or in any facility other than a hospital, when used in relation to inpatient hospital services; and
- As to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any equally effective service or supply in meeting the above tests.

Levels of care

Behavioral Health services may be provided in a variety of settings. The types, combinations of interventions, locations, sequence of treatments, duration and intensity of services have to be individualized based on the individual's symptoms, behaviors, emotional and cognitive abilities, age and developmental stage, community and educational resources and the family or other supports.



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Each component of treatment needs to be justified as medically necessary, and the evaluation of medical necessity should be updated regularly in response to progress and reevaluation and represent the least restrictive intervention in the least restrictive setting that is medically appropriate. The other resources in an individual's environment (such as schools or publicly funded agencies, community supports) should be identified and incorporated into the evaluation, planning, and service delivery of services to the member.

The settings in which treatment can occur can be defined in several ways, including by state licensing categories, by provider contracts, or by the clinical intensity of the services they provide. The differences are related to how intense and what type of treatment and supervision is needed.

- At the more restrictive end are hospitals and inpatient facilities (including observation units) with shifts of nurses, daily rounds with physicians and support from other medical services.
- Less intense is the residential setting or crisis stabilization unit, which is also a 24-hour-a-day setting, but with less medical involvement.

There are also:

- Day programs where the patient participates in 4 to 12 hours of therapy a day and then goes home or to a nearby unsupervised living arrangement;
- Intensive outpatient programs, usually two or more hours of group and individual therapy a day 3 to 7 days a week
- Routine outpatient settings
- Community-based care, such as self-help groups like Alcoholics Anonymous which are key components of any ongoing care

To be covered under the terms of Aetna's health plans, these facilities must have the appropriate license(s) and certification(s) mandated by governmental regulatory agencies. They must have documented emergency procedures, including procedures addressing treatment, provision of transportation and disaster evacuation plans to provide for the safety of patients.

They also must have an arrangement with a participating hospital in place for the immediate transfer of patients, and all practitioners at the facilities providing services to patients must be credentialed according to Aetna standards.

Aetna categorizes the various types of facilities/mental health services as follows:

Mental health **inpatient (IP)** should be under the care of an attending psychiatrist. For inpatient mental health care, there will be a minimum of five face-to-face sessions per week with a psychiatrist. Psychiatric care must be documented in the medical chart. In addition, a psychiatrist must be available on a 24/7 basis.

Mental Health **residential (RTC)** care should be under the care of an attending psychiatrist with documented treatment by a psychiatrist at least once per week, or more often as medically necessary. A licensed behavioral health professional (example, psychiatrist, psychologist, licensed social worker) must be on site and actively on duty 24 hours a day, 7 days a week.



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Members in mental health **partial hospitalization (PHP)** should be seen and treated by a psychiatrist (with care documented) twice weekly or more often as medically necessary. Mental health partial hospitalization clinical programming is provided at least four hours a session with sessions at least three times weekly or more often as medically necessary. All daily clinical programming must meet the minimum standard for duration and have a similar intensity of service regardless of the day of the week the care is provided.

Members in mental health **intensive outpatient program (IOP)** should be seen and treated by a psychiatrist (with care documented) as medically necessary. Mental health intensive outpatient clinical programming is provided at least two hours a day and at least three times weekly or more often as medically necessary. All daily clinical programming must meet the minimum standard for duration and have a similar intensity of service regardless of the day of the week the care is provided.

Other levels of care may be available in certain circumstances. These include **crisis stabilization** units and **observation** units. These programs offer a short-focused level of care to either stabilize the person for another level of care or to provide an opportunity to evaluate and refer to the most appropriate level of care.

Admission, diagnosis and discharge expectations

Aetna has several expectations about the admissions, diagnosis and discharge processes undertaken by facilities rendering behavioral health care to Aetna members. These include the following:

- Family outreach should occur within 72 hours of admission, and care must be available as clinically indicated.
- For all levels of care, there should be a comprehensive assessment performed at the time of admission that includes documenting clinical priorities or creating a problem list to be addressed, and a tentative discharge plan. The attending psychiatrist, physician or primary therapist must contact the member's primary care physician with member's consent within 48 hours of admission and at discharge as medically necessary. All contacts must be documented in the medical record.
- The primary therapist should personally contact a member's outpatient provider within 24 hours or first business day of admission with the member's consent. The outpatient provider will be made aware of clinical objectives, as appropriate. All contacts must be documented in the medical record.

For child and adolescent admissions, as appropriate and as permitted by state regulations, the primary therapist shall obtain parental (or custodial) consent to contact key participants in order to complete a diagnostic evaluation. Consistent with good clinical practice, key participants, including school-based personnel and primary care providers, shall be contacted within 72 hours of admission



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for completion of the diagnostic evaluation. All contacts must be documented in the medical record.

For all members, identifying the patient's ongoing needs after discharge will begin at the point of admission. Many diseases are chronic and relapsing conditions, and recovery is a process that requires support and maintenance treatment. Therefore, the expectation is that a first appointment with a behavioral health provider will be scheduled prior to discharge and will occur within seven days of discharge from an inpatient setting.

Purpose

The Level of Care Assessment Tool (LOCAT) is an instrument that an Aetna clinician uses to aid in his or her assessment of the level of care that is appropriate for effective treatment and medically necessary for a mental health patient. The term "Aetna clinician" may mean an Aetna care manager, an independent physician reviewer working on Aetna's behalf, or an Aetna medical director. LOCAT does not replace an Aetna clinician's independent clinical judgment.

Moreover, Aetna's assessment of medical necessity (using LOCAT or otherwise) is not intended to supplant or modify a treating practitioner's recommendations. The assessment by Aetna clinicians is limited to the specific issue of whether the treatment is covered under the terms of a member's health plan. Treating practitioners are solely responsible for clinical advice and treatment of members.

Time frame being considered

For the purposes of the LOCAT, the time frame being considered is that of **this presentation of the illness**. That is, it is the patient's current clinical presentation that forms the basis of the Aetna clinician's evaluation (although the Aetna clinician may take into account historical and demographic factors into this assessment). LOCAT should only be used by an Aetna clinician who has been instructed in its use.

Note: The generic term *practitioner* as used below refers to any individual outside of Aetna who may be treating or assessing the patient. This may be a psychiatrist, an advanced practice nurse or physician assistant working under the direct supervision of a psychiatrist, a nurse, social worker or other mental health professional.

Components that go into Aetna's coverage decision

Components that may go into Aetna's coverage decision include, but are not limited to:

- Data from the practitioner's comprehensive clinical interview and complete mental status examination
- Past clinical history (medical and psychiatric, including response to medication)
- Assessment of the current support system available to the patient including resources, patient's strengths and weaknesses, financial, housing, government programs, community treatment facilities, etc. that are available
- Family history
- Current medical status



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- Comprehensive risk assessment, including consideration of relevant demographic factors (age, ethnicity), comorbid substance use, medical conditions and support system, among other factors

Admission criteria

For Aetna to cover behavioral health care, the member must be properly admitted to the treating facility. Admission to any level of care requires an objective professional evaluation of the member's current condition and symptoms indicating a level of severity appropriate to the requested care, as evidenced by features of one or more of the following:

1. **Acute dangerousness:** Member presents with a level of risk related to harm toward themselves through suicide, self-injury, irritability or mania; or to others through aggression, assaultive or homicidal behavior.
2. **Functional impairment:** Member presents a temporary and reversible reduction in ability to function such as performing personal hygiene and bodily care activities, obtaining adequate nutrition, sleep, functioning in the workplace or at school, or becoming socially isolated.
3. **Mental status changes or co-occurring conditions:** Member presents with disrupted mood, disordered thinking, disorientation or other mental status changes that need care at the level requested; or there are medical or substance related issues that require care at the level requested.
4. **Psychosocial factors:** The member's challenges related to stress from family members, non-family members, housing, and work or school that have an impact.
5. **Additional modifiers:** The member's history of response to prior treatment, their personal resources such as intellect, characterological issues, and past history of violence or self-harm.

How each of these components is to be assessed is described below. The covered level of care at the time of the assessment is the highest level of care recommended in any of the dimensions below.

Note: Limitations in personal or social resources, in and of themselves, are not sufficient justification for admission to any level of care, without at least one valid DSM-5 diagnosis representing the direct cause of the patient's condition. That diagnosis may not be one that is excluded by the plan, and the patient's behavior is not due to an antisocial personality or part of a pervasive pattern of antisocial conduct.

Continued stay criteria

For Aetna to continue to cover care after a member has been properly admitted, the member must continue to require the level of care provided by that facility (that is, treatment at a lower, less restrictive level of care is not medically appropriate). In assessing whether continued care at the current level of care is covered, an Aetna clinician must evaluate the same factors as considered at admission (that is, acute dangerousness, functional impairment, mental status changes or co-occurring conditions, psychosocial factors and additional modifiers). In addition, for continued treatment at any level of care to be covered, progress must be evident to show that the condition



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or its symptoms are treatment-responsive, the member must continue to manifest symptoms justifying the principal DSM-5 diagnosis, *and* one or more of the following:

1. The intensity of service being delivered should be appropriate to the risk level that justified the admission
2. Complications arising from initiation of, or change in, medications or other treatment modalities
3. Need for continued observation
4. Persistence of symptoms such that continued observation or treatment is required
5. Increased risk of complications as a result of intervention or as a product of newly discovered conditions
6. Next steps have been identified for transition to a less restrictive level of care and additional time in treatment will reduce the probability of a readmission

Discharge criteria

Aetna will no longer cover care at a facility once the member has been discharged or meets discharge criteria. The member is ready for discharge when he or she satisfies any of the following criteria:

- The member's clinical priorities have been addressed.
- The member's symptom intensity or impairment in functioning no longer requires the level of observation or intensity of service at the requested level of care.
- Further professional intervention is not expected to result in significant improvement in the member's condition.
- The member leaves against medical advice (AMA).

Aetna clinicians should endeavor to obtain detailed information from the practitioner assessing or treating the patient about the events leading to the crisis or behavior. Past history, previous treatment, and review of present stressors and support systems are helpful in making an accurate coverage decision.

It is essential to be familiar with the capabilities of a local provider network to support the member.

DIMENSION 1. ACUTE DANGEROUSNESS

This dimension identifies elements of dangerousness that represent or describe a member's behavior. To evaluate dangerousness, the mental health practitioner usually assesses suicidal intent and homicidal intent. However, the additional sub-dimensions of self-injuriousness and irritability/aggression/mania help provide a more complete clinical picture of a member's mental health. These sub-dimensions are sensitive toward members who present with behaviors resulting from impaired judgment secondary to a mental illness. Some clinical situations of impaired judgment may be addressed directly by the family or by an agency dealing with the member. (Example: A manic member who is driving a car in a reckless manner should have access to the vehicle prevented.) If the family or agency cannot alleviate the dangerous behavior, then it should



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be noted in this dimension.

A. Suicidal intent

Please select the level of care corresponding to the most significant symptoms below. The symptoms listed are not intended to be an exhaustive list, but are examples that represent anchor points along a continuum of symptoms with increasing degrees of clinical significance. The Aetna clinician is to use these descriptions to aid in the decision-making process that determines the medically necessary level of care appropriate for effective treatment. The Aetna clinician must apply clinical judgment in selecting the correct response from below:

None: No element of suicidality.

OP/IOP: Fleeting thoughts of suicide, but no plan, intent or actions. Fleeting is defined as occasional thoughts that do not persist most days.

PHP: Persistent thoughts of suicide with no feasible plan and no definite intent. Any recent attempt was non-lethal, impulsive or occurred in the presence of others; member may have continued thoughts but no plan or intent. Member is able to develop a safety plan without reservation.

RTC/IP: Suicidal plan and intent, but without organized means to execute the plan. The member is able to develop a plan for safety with some reservations or conditions (only in a facility, etc.), or the member is not able to develop a plan for safety but is well known to the practitioner/evaluator and is not believed to be at serious risk. Or, an attempt has been made, and there was a plan with intent, but the patient exhibits some remorse. The member is now able to develop a plan for safety with some reservations or conditions (only in a facility, for example), or the member is not able to contract for safety but is well known to the practitioner/evaluator and is not believed to be at serious risk.

IP: Member has a realistic plan and intent to commit suicide, plus the means to execute the plan. Premeditated suicide attempt, alone, with efforts to avoid detection even if the attempt had a low potential for being lethal but the member believed that the attempt could have been lethal. The member continues to voice a desire to die.

B. Self-injuriousness

Please select the level of care corresponding to the most significant symptoms below. The symptoms listed are not intended to be an exhaustive list, but are examples that represent anchor points along a continuum of symptoms with increasing degrees of clinical significance. The Aetna clinician is to use these descriptions to aid in the decision-making process that determines the medically necessary level of care. The Aetna clinician must apply clinical judgment in selecting the correct response from below:



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None: No evidence of attempts to self-inflict injury, no symptoms of an eating disorder.

OP/IOP: Where medical intervention is typically not warranted. Self-inflicted scratches or abrasions, hair pulling, hitting self, or otherwise causing self-harm.

IOP: A pattern of restricting, bingeing or purging; abuse of laxatives and diet pills (over-the-counter, prescription or illicit drugs); or use of enemas or herbal supplements designed to cause purging or flushing of the system.

PHP: Medical intervention may be required. Self-inflicted cuts, possibly requiring sutures, banging head, hitting objects, self-induced falls, or otherwise causing self-harm; or a need for supervision at all meals to avoid restricting or purging. Failure to restore weight despite an apparently adequate intake of calories.

RTC: Medical intervention is necessary. Self-inflicted wounds and or burns, overmedicating self or other self-harm; or there are unstable vital signs or metabolic abnormalities confirmed by laboratory values. *Strict supervision of all meals and bathroom use to mitigate ED behaviors; requires 24-hour high structure to promote treatment adherence; no need for 24 hour medical monitoring.*

IP: Twenty-four-hour medical monitoring may be necessary. In the absence of suicidality, self-inflicted attempts to hang self (for autoerotic reasons), or other self-harm where severe injury results; medication refusal, where without the medication, the member's dangerous or self-injurious behavior would persist; or intravenous fluids, nasogastric tube feedings or multiple daily laboratory testing is needed. Behavior that demonstrates impaired judgment to the extent that serious harm or death may result (for example, a member with an eating disorder with electrolyte abnormalities, cardiomyopathy, serious bradycardia [for example, a heart rate below 40 in an adult, a blood pressure below 90/60, or a temperature below 97]; or member needs direct supervision to comply with medication or meals).

C. Homicidal intent

Please select the level of care corresponding to the most significant symptoms below. The symptoms listed are not intended to be an exhaustive list, but are examples that represent anchor points along a continuum of symptoms with increasing degrees of clinical significance. The Aetna clinician is to use these descriptions to aid in the decision-making process that determines the medically necessary level of care. The Aetna clinician must apply clinical judgment in selecting the correct response from below:

None: No thoughts of homicidality or dangerousness.

OP/IOP: Fleeting thoughts of homicide, but no plan, intent or actions taken in furtherance of these thoughts. Fleeting is defined as occasional thoughts that do not persist most days.



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PHP: Homicidal thoughts may be fleeting or persistent, and the member has a plan, but it is not organized or realistic, and there is minimal intent. There are thoughts of homicide without an organized plan. There is no current action in furtherance of killing someone, or means to kill someone.

IP: There are continuous thoughts about homicide with a feasible plan and intent to commit homicide. The member has the means to complete it.

D. Irritability/aggression/mania

Please select the level of care corresponding to the most significant symptoms below. The symptoms listed are not intended to be an exhaustive list, but are examples that represent anchor points along a continuum of symptoms with increasing degrees of clinical significance. The Aetna clinician is to use these descriptions to aid in the decision-making process that determines the medically necessary level of care. The Aetna clinician must apply clinical judgment in selecting the correct response from below:

None: The member demonstrates self-control, or has not engaged in any inappropriate arguments with other people.

OP: Hypomania, or occasional inappropriate arguments with other people, without physical violence.

IOP: Daily or frequent inappropriate arguments with other people, without physical violence.

PHP: Behavior evidencing disorganized thought processes or inability to engage appropriately in social interactions.

RTC: Intense inappropriate arguments occur almost continuously; and/or arguments occur almost daily and involve periodic physical confrontation and/or violence but without the use of an implement or weapon; or grandiose or impaired judgment, or markedly increased activity level; or severe psychosis impairing functioning.

IP: Agitation or behavior with a high potential for causing physical harm. Physical violence with the use of implements or weapons (knife, gun, bat, scissors, etc.).

DIMENSION 2. FUNCTIONAL IMPAIRMENT

This dimension addresses the degree to which psychological problems affect the patient's functioning, vary from the patient's own typical baseline, and contribute to the ability to survive or maintain him/herself in the environment. The assessment of functional impairment must be made each time the patient is assessed, to determine whether the patient's level of functioning may have



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changed from the previous baseline level of functioning. The Aetna clinician should review the previous baseline level of functioning (to the extent Aetna has a record of it), and the possibility of concurrent chemical dependency that may contribute to or explain the functional impairment.

Please select the level of care corresponding to the most significant symptoms below. The symptoms listed are not intended to be an exhaustive list, but are examples that represent points along a continuum of symptoms with increasing degrees of clinical significance. The Aetna clinician is to use these descriptions to aid in the decision-making process that determines the medically necessary level of care. The Aetna clinician must apply clinical judgment in selecting the correct response from below:

None: The member's social interactions are adequate without evidence of significant social withdrawal. Educational/occupational functioning is adequate. The member's appetite and nutritional intake is adequate, and there is no concern about it at present. No report of any concern about sleeping patterns.

OP: Report of some occasional sleep disturbances. These occasional sleep difficulties may be related to situational precipitants (stress in life, pain or discomfort from a medical problem, crying baby, etc.). Member identifies stress at school or work and has difficulty performing responsibilities due to poor concentration or anxiety, without related absenteeism.

IOP: Social withdrawal, or limited range of social contacts or interactions (in comparison to baseline). The member may withdraw from some social situations. The member's withdrawal does not include his/her occupational or school life. Appetite disturbances have resulted in weight gain or loss over the last month. The member is engaging in restricting, bingeing or purging behavior at least five times per week over the last two weeks. Sleep is significantly impaired as measured by duration. There may be a combination of initial or terminal insomnia or frequent awakenings or hypersomnia present for more than eight weeks.

PHP: Withdrawal from most situations, including social and occupational/educational. Member frequently limits social involvement/activity at work/school and at home in some way (for example, stays home for several consecutive days to avoid contact with peers, avoids almost all contact or interaction with spouse/family, avoids involvement in child-rearing activities, discipline, etc.). Impaired performance in job or school, with a moderate decline in performance from prior level of functioning, and/or absenteeism. Disciplinary action may have been taken against the patient at work or school due to inappropriate or ineffective behavior. Destruction of property at school or work may be present.

RTC: Appetite disturbances have resulted in significant (20 lb or more for an adult) weight gain or loss over the last month. The member is engaging in restricting, bingeing or purging behavior at least daily over the last two weeks. Either total or almost total withdrawal from all situations, including social and occupational/educational. Unable to care for him/herself. Near complete disruption of relationships. Member fired, expelled and unable to work/attend school due to



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mental status. An inability to obtain basic needs (such as food, shelter, medical care) due to mental illness.

IP: Member's physical health status is such as to suggest imminent danger, due to the member's inability to independently consume sufficient calories/fluids to provide basic nourishment. Imminent danger is demonstrated by the member needing medical treatment to ensure safety (IV fluids, electrolyte replacement, etc.).

DIMENSION 3. MENTAL STATUS AND COMORBID FACTORS

A properly performed mental status examination assists a clinician in determining whether the member is psychotic. Psychosis is a key factor in determining the appropriate level of care. This dimension measures current psychological functioning using selected components of a mental status examination conducted by the treating practitioner. Alcohol and substance abuse in a patient can dramatically complicate and change the level of care needed. Acute intoxication or withdrawal syndromes requiring intervention may not be appropriate for treatment in a pure mental health setting. There is a need for a close working relationship between the medical caregivers and mental health professionals. Adequate communication, transfer of information and open discussions are of the utmost importance in improving the quality of care, as well as the efficacy and safety of treatment. It is the responsibility of the treating practitioner to have discussions with the medical physician regarding the medical signs and symptoms related to the member's psychiatric manifestations. It is the responsibility of the medical physician when medical signs and symptoms are present to provide that information to the mental health professional or evaluating facility upon referral of the member.

Please select the level of care corresponding to the most significant symptoms below. The symptoms listed are not intended to be an exhaustive list, but are examples that represent anchor points along a continuum of symptoms with increasing degrees of clinical significance. The Aetna clinician is to use these descriptions to aid in the decision-making process that determines the medically necessary level of care. The Aetna clinician must apply clinical judgment in selecting the correct response from below:

None: Neat and well-groomed: independent hygiene or at expected baseline for the member. No thought disorder; thought content is appropriate. Oriented in all spheres. No problem with alcohol or substance abuse, or may use occasionally. No pathological behavioral effects of use. No medical illness affecting management, compliance or response to psychiatric treatment.

OP: Mood is sad or depressed, constricted, angry, flat, anxious, but congruent with mood. Ruminations, somatic preoccupation, obsessions, compulsions, phobias or de-realization are present. The member denies any problems with alcohol and/or substance use, but family, friends, or associates at work believe there is a problem. There may be some problems noted secondary to substance usage (work, family, school, medical). The member presents with psychiatric signs and symptoms that may be due to a medical illness, (therefore a medical work-up is indicated) and/or



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there are known medical problems that do not interfere with routine psychiatric care of the member.

IOP: Unkempt: Member is performing hygiene activities needed to maintain physical health but not at the premorbid baseline expected for this member. Speech is slow and low volume; selectively mute, content of speech demonstrates paucity of thought. Pressured or rapid speech, but interruptible; content of speech demonstrates circumstantial, tangential thought processes. Difficulty concentrating, decreased interest in pleasurable things (anhedonia), increased libido, tics or automatisms (not typical for the member at baseline). Affect not appropriate to content of discussion. Member admits to hazardous alcohol and/or substance use. The member describes a history of substance-induced amnesia (blackouts). Known medical problems do not/or moderately interfere with routine psychiatric care of the member, however, the medical condition must be monitored closely by the primary or other physician. Close contact between the mental health practitioner and the medical practitioner is needed. Examples of relevant conditions include pain syndromes, eating disorders.

PHP: Malodorous: Member is NOT performing hygiene activities needed to maintain health and safety, requires external prompting to perform hygiene activities. Pressured or rapid speech that is not interruptible, or with yelling/screaming. Fixed delusions, and member's functioning is affected. Not oriented to time or place. Psychomotor agitation or psychomotor retardation. Auditory and/or visual hallucinations. A member who becomes suicidal, homicidal, assaultive or psychotic when under the influence. (The suicidality, homicidity and/or the psychosis are clearly related to the substance.)

RTC: Member is unable to bathe/shower or take appropriate steps to maintain hygiene without direct assistance. Dependent care for all hygiene: would be unclothed but for assistance. Expansive and/or grandiose; severe mood lability with rapid switches from one extreme to another. The member's delusions are so pervasive that most waking moments are spent in the delusional system, thus rendering the member inaccessible to verbal interventions. Command hallucinations, and the member has or will act on them. Ideas of reference, circumstantial or tangential thinking, paranoia, resistance to treatment. Thought blocking, loose associations, thought insertion, thought broadcasting, dissociation. Catatonia, bizarre posturing. Not oriented to person or circumstance. Member with substance use, who becomes suicidal, homicidal or assaultive when under the influence. The member has a potentially lethal medical condition that is related to substance use. The member has a serious psychiatric condition with a medical condition that requires ongoing medical attention (for example, intramuscular medications, member refuses life-sustaining medications, etc.).

IP: Fixed delusions and the member may act on the delusion having an effect on the member's or other's safety. The member has a psychiatric condition (but is too behaviorally unstable for a general medical setting) with a history of a serious medical condition or complication. Because of this history and current symptoms, the member must be observed in a facility with round-the-clock nursing and medical coverage until the member is medically stable. Examples of relevant



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conditions include withdrawal seizures, dehydration, lithium toxicity.

NOTE: If the co-occurring medical symptoms are consistent with an RTC or IP level of care, the medical situation must immediately be reviewed by an Aetna medical director.

DIMENSION 4. PSYCHOSOCIAL FACTORS

Trying to understand why a member presents for treatment when he/she does is important in determining the treatment needed for that individual. Often, the member or his/her family can identify stresses that precipitated the need for treatment. It is difficult to reliably measure the amount of support that a patient can count upon during an illness. Most competent practitioners spend a great deal of time exploring these resources. In making a level of care decision, take this into account. Psychosocial issues, except as they may they create a psychiatric condition, cause dangerousness, or psychosis (leading to poor medication or treatment adherence) do not alone justify anything other than outpatient care.

Please select the level of care corresponding to the most significant symptoms below. The symptoms listed are not intended to be an exhaustive list, but are examples that represent anchor points along a continuum of symptoms with increasing degrees of clinical significance. The Aetna clinician is to use these descriptions to aid in the decision-making process that determines the medically necessary level of care. The Aetna clinician must apply clinical judgment in selecting the correct response from below:

None: There are no identified stressors on the member, and the member's housing situation is stable.

OP: There is pressure from the family to achieve, or there are overprotective or lax parents or guardians. An older or younger sibling moves from the home, discord with immediate family members, pregnancy of a parent, minor child moving between the homes of divorced/separated parents, triggering of significant disturbing memories of past physical or sexual abuse by a family member. Flashbacks or preoccupation with a stressful event. Member has a place to live, but it is substandard and/or in a high-crime and/or high-drug area. Declining grades and/or frequent unexcused absences from school or work (fewer than 10 per year) and/or stressful work schedule, difficult work conditions. Recent suspension from school or work for nonattendance, fighting or substance use. The support system is antagonistic toward the member and/or toward the member's recovery, and/or financial resources as it relates to getting care may be a problem.

IOP: Serious illness of a family member; disruption of a family by separation, divorce, or estrangement; substance abuse/dependence in a family member. Member is being targeted by peers or others for violence, unwanted pregnancy, death or illness in a friend, triggering of significant disturbing memories of past sexual abuse by a non-family member. There is limited support due to availability or interest, and/or transportation to treatment may be a problem.



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Removal (placement) of the member out of the home, current or recent physical or sexual abuse by a family member, recent death of an immediate family member.

PHP: Recent extreme violence directed toward the member at work or school or from neighbors or peers, current or recent physical or sexual abuse by a non-family member. The member has transient housing or is awaiting placement (foster home, residential school, CRR, etc.), or the member has lost his/her place to live. Recent expulsion from school for any reason, or greater than 20 unexcused absences this academic year; or forced unemployment. The member is alone without family and/or significant agency support, or the member does not choose to utilize the available support system. Getting food or housing may be a problem.

Note: Limitations in personal or social resources, in and of themselves, are not sufficient justification for admission to a level of care, without at least one valid DSM-5 diagnosis representing the direct cause of the member's condition. That diagnosis may not be one that is excluded by the plan, and the member's behavior is not due to an antisocial personality or part of a pervasive pattern of antisocial conduct.

DIMENSION 5. ADDITIONAL MODIFIERS

Aetna plans cover acute, treatable psychiatric illnesses that would be expected to improve in a given level of care. As indicated in the introduction to LOCAT, that treatment is in the least restrictive setting. However, the member's history of response to prior treatment, their personal resources such as intellect, or underlying characterological issues, and past history of violence or self-harm may influence the decision about which level of care is medically necessary.

Please select the level of care corresponding to the most significant symptoms below. The symptoms listed are not intended to be an exhaustive list, but are examples that represent anchor points along a continuum of symptoms with increasing degrees of clinical significance. The Aetna clinician is to use these descriptions to aid in the decision-making process that determines the medically necessary level of care. The Aetna clinician must apply clinical judgment in selecting the correct response from below:

None: There is no history of suicide attempts or assault on others. The member is highly motivated, has no intellectual deficits, and can appropriately utilize supports, resources and can engage in self-help or community-based treatment

OP: There is a history of symptom remission but not sustained, or a history of symptom recurrences. The member is ambivalent about treatment, personality factors (self-defeating characteristics, for example) may impact effort toward adhering with treatment, intermittently conflictual relationships with supports or practitioners. There are health literacy factors, learning differences or limited education affecting ability to follow directions. There is a history of completed suicide in a first-degree relative, or a history of significant violence by a first-degree relative (for example, an act resulting in a need for medical attention for the victim, or legal



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consequences for the relative).

IOP: There have been treatment failures, rapid recurrences of symptoms or only partial remission of symptoms. The member lacks insight into his/her condition, is uncooperative with following up with treatment (medication, therapy visits, medical appointments, self-help group attendance) or is not able to understand his/her responsibilities related to treatment. Becomes hostile with practitioners and other supports or resources. The member shows no motivation to change or is not willing to engage with practitioners. Logistics represent a barrier to accessing care. Serious intellectual, developmental, emotional or deficits in reality testing result in ineffective treatment.

PHP: Serious and disabling symptoms remain despite adequate treatment; failure to return to previous baseline level of functioning, despite adherence to treatment. Actively sabotages treatment; refuses to participate in treatment. There is a prior history while serious and disabling symptoms remain of the member losing control of anger, rage or aggressive thoughts and becoming violent, or there has been a history of prior suicide attempts by the member of a severity that required medical intervention. Past, premeditated suicide attempt(s), alone, with efforts to avoid detection even if the attempt had a low potential for being lethal but the member believed that the attempt could have been lethal.

DIMENSION 6. GLOBAL INDICATORS

All of the following must be considered:

1. Patient presents at least one valid DSM-5 diagnosis not excluded by the plan.
2. Patient's condition must be directly attributable to the designated mental disorder and not to an antisocial personality or be a part of a pervasive pattern of antisocial conduct.
3. Professional intervention is considered likely to be effective and is essential to contain risks presented and provide for improvement.
4. The intensity of services being provided conforms with the standards of the levels of care as defined by Aetna.
5. Treatment at a lower level of care is not possible because the individual requires the requested level of observation and/or treatment.

If any one of the above global indicators is not met, the request must be reviewed with a medical director.



Level of Care Assessment Tool

LOCAT SUMMARY TOOL

LOCAT: Approval for Admission to a facility/program eligible under the terms of the member's Plan

Requested Level of Care _____. Level of Care Medically Necessary for Admission _____.

Dimension 1: acute dangerousness

- A. Suicide risk: supports _____ as the medically necessary level of care
- B. Self-injury: supports _____ as the medically necessary level of care
- C. Risk to others: supports _____ as the medically necessary level of care
- D. Aggression: supports _____ as the medically necessary level of care

Dimension 2: functional impairment: supports _____ as the medically necessary level of care

Dimension 3: mental status and comorbidities: supports _____ as the medically necessary level

Dimension 4: psychosocial factors: supports _____ as the medically necessary level of care

Dimension 5: additional modifiers: supports _____ as the medically necessary level of care

Dimension 6: global indicators/quality concerns: these are met _____(Y/N).

(Note: If any one of the global indicators is not met, the request must be reviewed with a supervisor or medical director.)

LOCAT: Continued Stay: Approval for Current Level of Care

Level of Care Requested and Medically Necessary for Continued Stay_____.

Dimension 1: acute dangerousness

- A. Suicide risk: supports _____ as the medically necessary level of care
- B. Self-injury: supports _____ as the medically necessary level of care
- C. Risk to others: supports _____ as the medically necessary level of care
- D. Aggression: supports _____ as the medically necessary level of care

Dimension 2: functional impairment: supports _____ as the medically necessary level of care

Dimension 3: mental status and comorbidities: supports _____ as the medically necessary level

Dimension 4: psychosocial factors: supports _____ as the medically necessary level of care

Dimension 5: additional modifiers: supports _____ as the medically necessary level of care

Dimension 6: global indicators/quality concerns : these are met _____(Y/N).

(Note: If any one of the global indicators is not met, or if there are quality of care concerns, the request must be reviewed with a supervisor or medical director.)

At least one of the following is met:

- The current level of care is medically necessary for the severity of symptoms/behaviors _____(Y/N)
- The current level of care is medically necessary to address complications of treatment_____(Y/N)
- Additional time at the current level of care will reduce the risk of re-admission_____(Y/N)

LOCAT Continued Stay: Approval for Change in Level of Care

Current Level of Care _____. Level of Care Medically Necessary for Continued Stay_____.



Level of Care Assessment Tool

Dimension 1: acute dangerousness

- A. Suicide risk: supports _____ as the medically necessary level of care
- B. Self-injury: supports _____ as the medically necessary level of care
- C. Risk to others: supports _____ as the medically necessary level of care
- D. Aggression: supports _____ as the medically necessary level of care

Dimension 2: functional impairment: supports _____ as the medically necessary level of care

Dimension 3: mental status and comorbidities: supports _____ as the medically necessary level

Dimension 4: psychosocial factors: supports _____ as the medically necessary level of care

Dimension 5: additional modifiers: supports _____ as the medically necessary level of care

Dimension 6: global indicators/quality concerns: these are met _____(Y/N).

(Note: If any one of the global indicators is not met, or if there are quality of care concerns, the request must be reviewed with a supervisor or medical director.)

All of the following are met:

- The current level of care either does not provide for, or exceeds, the patient's medically necessary treatment needs.
- The current level of care either does not provide for, or exceeds, any treatment needs for complications.
- Change in the current level of care will not increase the risk of re-admission.

LOCAT Approval for Discharge to Outpatient Services

Dimension 1: acute dangerousness

- A. Suicide risk: supports outpatient as the medically necessary level of care ____ (Y/N)
- B. Self-injury: supports outpatient as the medically necessary level of care ____ (Y/N)
- C. Risk to others: supports outpatient as the medically necessary level of care ____ (Y/N)
- D. Aggression: supports outpatient as the medically necessary level of care ____ (Y/N)

Dimension 2: functional impairment: supports outpatient as the medically necessary level of care ____ (Y/N)

Dimension 3: mental status and comorbidities: supports outpatient as the medically necessary level ____ (Y/N)

Dimension 4: psychosocial factors: supports outpatient as the medically necessary level of care ____ (Y/N)

Dimension 5: additional modifiers: supports outpatient as the medically necessary level of care ____ (Y/N)

Dimension 6: global indicators/quality concerns are met for outpatient care. ____ (Y/N)

(Note: If any one of the global indicators is not met, or if there are quality of care concerns, the request must be reviewed with a supervisor or medical director.)

All of the following are met:

- The intensity of service medically necessary can be delivered in an outpatient setting.
- Severity of symptoms can be managed safely and effectively in an outpatient setting.
- Complications of treatment can be managed safely and effectively in an outpatient setting.
- Treatment in an outpatient setting will not increase the risk of re-admission.

LOCAT Assessment of Custodial Care/Investigational & Experimental Services

In no event will the following services or supplies be considered **medically necessary**:



Level of Care Assessment Tool

- Custodial care, supportive care or rest cures, including the following:
 - Services and supplies that are primarily intended to help you meet personal needs
 - Services or supplies that do not require the technical skills of a health care provider such as a nurse or therapist
 - Any services that a person without medical or behavioral health training could be trained to perform
 - Help with daily living activities, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods
 - Watching or protecting you
- Experimental or investigational drugs, devices, treatments or procedures as determined by Aetna.

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TTY: 711

For language assistance in your language call the number listed on your ID card at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al número que figura en su tarjeta de identificación. (Spanish)

ID

(Chinese)

Pour une assistance linguistique en français appeler le numéro indiqué sur votre carte d'identité sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang nakalistang numero sa iyong ID card nang walang bayad. (Tagalog)

T'áá shí shizaad k'ehjí bee shíká a'doowoł nínízingo Diné k'ehjí naaltsoos bee atah nílįįgo nanitinígíí béésh bee hane'é bikáá' áají' t'áá jíík'e hólne'. (Navajo)

Benötigen Sie Hilfe oder Informationen auf Deutsch? Rufen Sie kostenlos die auf Ihrer Versicherungskarte aufgeführte Nummer an. (German)

Për asistencë në gjuhën shqipe telefononi falas në numrin e regjistruar në kartën tuaj të identitetit (ID). (Albanian)

ለአማርኛ ቋንቋ እገዛ በመታወቅያዎ ላይ በተጠቀሰው ቁጥር በነጻ ይደውሉ (Amharic)

(Arabic) للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني المذكور في بطاقتك التعريفية

Լեզվի ցուցաբերած աջակցության (հայերեն) Ձանգահարեք թիվը նշված է ձեր ID քարտի առանց գնով: (Armenian)

Niba urondera uwugufasha mu Kirundi, twakure ku busa ku inomeru iri ku ikarata karangamuntu yawe. (Bantu-Kirundi)

Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawga ang numero nga gilista sa imong kard sa kailhanan nga walay bayad. (Bisayan-Visayan)

বাংলায় ভাষা সহায়তার জন আপনার আইডি কার্ডে যন র তালিকাভূ রেয়েছ িবনামুেলে তেত কল ক ন। (Bengali-Bangala)

ဂြိတ်နွံခံစရာမလိုဘဲ (ရူမနုမတဘာသာစကား) ဂျူဖုဒု ဘာသာစကားအကူအညီရယူရန် သင့်အိုင်ဒီကတ်

ပေးငှကြင့် ပေးထားသည့်ဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။ (Burmese)

Per rebre assistència en (català), truqui al número de telèfon gratuït que apareix a la seva targeta d'identificació. (Catalan)

Para ayuda gi fino' (Chamoru), ågang l numiru ni mangaige gi iyo-mu 'ID card', sin gåstu.. (Chamorro)

Aetna complies with applicable federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,

Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

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