LEVEL OF CARE ASSESSMENT TOOL (LOCAT)

UTILIZATION REVIEW AND BENEFIT DETERMINATION CRITERIA COMPARISON

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INTRODUCTION:
The Level of Care Assessment Tool (LOCAT) is a clinical behavioral health patient management instrument developed by Aetna. The LOCAT is an instrument used to guide and track level of care decisions for Aetna members in need of behavioral health services. The LOCAT also serves to improve and standardize data collection and documentation for the behavioral health provider network.

What is LOCAT?
The Aetna Level of Care Assessment Tool or "LOCAT" is a clinically-based scoring system created to aid Aetna in the decision-making process. The LOCAT helps Aetna determine the appropriate level of care for effective treatment. LOCAT was developed to provide guidelines for evaluating the medical necessity of care for mental health disorders.

In treating behavioral health symptoms and diagnosis, LOCAT is used to help determine:
- the appropriate levels of care
- the type of care required for patients - from routine outpatient services to specialized inpatient treatment
- the medical necessity of all the various treatment options

LOCAT is to be used as a guideline to help evaluate a patient’s symptoms. The tool helps Aetna by identifying and scoring various behavioral health dimensions, and by narrowing down some of those dimensions into sub-dimensions. This analysis creates a more complete clinical picture of the patient.
When was LOCAT developed?

The first version of the LOCAT was developed in 1991. The tool was designed to guide care for mental health treatment much in the same way that the American Society of Addiction Medicine (ASAM) criteria provides care guidelines for chemical dependency. This Level of care Assessment Tool (LOCAT) was developed to provide guidelines for evaluating the medical necessity of care for mental health disorders.

The intent of the LOCAT tool is not to guide care for substance related and addictive disorders but may be used in conjunction with such guidelines when the patient has been diagnosed with both a Mental Health and Addictive Disorder. These guidelines are not a replacement for good clinical judgment but do provide a foundation for reviewing medical necessity. In addition, the benefits available to a covered person are based on the purchased Plan of Benefits.

The LOCAT developers believed that it is crucial to see the patient as a whole person, with various psychological and social influences, and not just a diagnosis. To that end, the levels of care decision making is not primarily diagnosis driven, but instead takes into account how the individual functions in various settings/situations.
Who developed LOCAT?

Aetna staff believed that bringing in outside experts could benefit the development of a tool to assist with determining medical necessity. To that end, a Blue Ribbon Panel of outside expert psychiatrists were selected to direct the project from 1990-1991. They utilized accepted community standards of care to determine which data should be considered when a patient is in need of mental health services. LOCAT 1.0 was developed on this basis. This first version of the tool was put into daily patient management operations for approximately two and a half years. It was utilized as a guideline (versus criteria) by Behavioral Health Clinical Care Coordinators and Medical Directors responsible for patient management decisions.

Aetna annually solicits feedback on the tool proactively from outside expert psychiatrists, psychologists, social workers, licensed therapists and other stakeholders. Workgroups review the scientific literature for studies or guidelines related to medical necessity criteria, treatment settings, length of stay or intensity of services that correlate with outcomes. Ongoing feedback from professionals and providers, outside of the company, confirms the validity of the LOCAT as a guideline for treatment.

What is Aetna’s approach to mental illness?

At Aetna, we understand that behavioral health conditions may be lifelong challenges for both the individual and their loved ones. We also know that behavioral health conditions often represent points on a continuum of several different conditions with varying levels of severity and differing presentations. Equally important to consider is the patient’s environmental and social context and the impact of the condition upon these other areas of the patient’s life. Because there is no single and correct treatment setting or approach that universally works best in all circumstances, the LOCAT tool offers a guideline in place of firm criteria. Unlike medical treatment, behavioral health care is less about a “cure” in the conventional sense and more about improved functioning, adaptability, ability to interact socially and communication skills. The goal of mental health treatment is reduction in symptom intensity as well as improvements in the areas listed above. The LOCAT is designed to address this complete view of the patient and guide the appropriate level of treatment.
What is Aetna’s approach to mental illness? (continued)

In administering the member’s plan, Aetna’s approach aligns with what the scientific literature in the field of psychiatry shows, namely, that many diseases, including Behavioral Health conditions, are chronic conditions prone to relapse. Recovery is a process that requires ongoing support and maintenance treatment. According to the science, the longer that support and treatment can occur, the more likely it is that symptoms will remain under control. In addition to on-going behavioral health treatment, other factors, such as a supportive, real-world environment, appear to impact treatment success and recovery. Patients with the benefit of stronger biological, psychological and social foundations may require a more moderate treatment approach. Length of treatment as a single variable has not been shown to correlate with a better outcome, so the LOCAT takes into account other factors as mentioned above. It may be that as long as the person remains engaged in a recovery process, progress may occur, even if that support is a only in a self-help program like Alcoholics Anonymous/Narcotics Anonymous.

The ability to function within the person’s social, family and work environments appears to correlate to a strong recovery process even when facing difficult life circumstances beyond the disease. In practical terms, this means that for each individual, there will need to be a connection to a network of supports, robust enough to maintain reasonable symptom remission in the real-world, rather than just in the somewhat artificial world of a hospital or other facility setting where there are counselors available 24 hours/7 days a week and safeguards to deal with symptoms that may intensify. The inpatient environment has not proven to be a test of a person’s strengths in facing the challenges of day-to-day life. Aetna therefore, supports treatment in the least restrictive setting because that means treatment is occurring in the most real-world setting. By real-world, we mean the setting most likely to test the person’s skills, presenting the person opportunities to confront the people, places and things that could cause symptoms to resurface and thereby build on their strengths. Further, there is limited science that supports that a fixed length of stay in an institution ensures superior outcomes or prevents the patient from returning to the same facility to repeat the treatment. Individualized treatment has proven to be more critical to the recovery of the person than some set time in an institution. Many individuals do not have a need for 24/7 care, or only need a very brief period to stabilize in a 24/7 setting. Unfortunately, with behavioral health conditions, recovery may not occur along a smooth trajectory, and many individuals may need to move from one setting to another in either direction. The patient’s social setting and support system plays an important role in determining inpatient vs. outpatient care as well as length of care.
What does medically necessary mean?

Medically necessary - means services that are appropriate and consistent with the diagnosis in accordance with accepted medical standards. To be medically necessary, the service or supply must:

- 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 the 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 the 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.
What is not medically necessary?

The list below outlines the services or supplies that are not considered medically necessary:

- Services or supplies that do not require the technical skills of a medical, mental health or dental professional;
- Custodial care, supportive care or rest cures;
- Services or supplies furnished mainly for the personal comfort or convenience of the patient, any person caring for the patient, any person who is part of the patient’s family or any health care provider;
- Services or supplies furnished solely because the Plan participant is an inpatient on any day when their disease or injury could be diagnosed or treated safely and adequately on an outpatient basis;
- Services furnished solely because of the setting if the service or supply could be furnished safely and adequately in a physician’s or dentist’s office or other less costly setting; or
- Experimental services and supplies, as determined by Aetna.

How does Aetna determine which therapies to cover?

The Aetna Clinical Policy Council evaluates the safety, effectiveness and appropriateness of medical technologies and therapies (i.e., drugs, devices, and procedures used in medical care, and the organizational and supportive systems within which such care is provided) that are covered under Aetna plans, or that may be eligible for coverage under Aetna plans. In making this determination, the Clinical Policy Council will review and evaluate evidence in the peer-reviewed published medical literature, information from the U.S. Food and Drug Administration and other Federal public health agencies, evidence-based guidelines from national medical professional organizations, and evidence-based evaluations by consensus panels and technology evaluation bodies.
How does Aetna determine which therapies to cover? (continued)

In determining whether a medical technology is medically necessary and established, the Council will consider whether the following five criteria are met:

- The technology must have final approval from the appropriate governmental regulatory bodies.
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.
- The technology must improve the net health outcome.
- The improvement must be attainable outside investigational settings
- The technology must be as beneficial as any established alternatives.

Aetna supports the use of evidence-based research to determine whether a therapy could be eligible for coverage under the health plan.

Where can treatment occur?

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 has 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. Each component of treatment needs to be justified as medically necessary, and updated regularly in response to progress and reevaluation. The treatment plan must also 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 for 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.
Where can treatment occur? (continued)

Types of care included:
- At the more restrictive end, there 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 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 three to seven days a week, and there are routine outpatient settings.
- Community based care such as self-help groups like Alcoholic Anonymous are key components of any ongoing care.

Which facilities are covered by Aetna plans?

To be covered by an Aetna plan, the facility must have the appropriate license(s) and certification(s) mandated by governmental regulatory agencies. It must have documented emergency procedures, including procedures addressing treatment, provision of transportation and disaster evacuation plans to provide for the safety of patients. Facilities must have an arrangement with a Participating Hospital in place for the immediate transfer of patients; and all providers at facility providing services to patients must be credentialed according to Aetna standards.

Aetna contracts with facilities generally contain the following requirements:

Mental health **inpatient (IP)** must 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 treatment record. In addition a psychiatrist must be available as medically necessary on a 24/7 basis.
Which facilities are covered by Aetna plans? (continued)

Mental Health residential (RTC) care must be under the care of an attending psychiatrist with documented treatment as medically necessary by a psychiatrist. Mental Health residential care members must be treated by a Psychiatrist at least once per week. A licensed behavioral health professional must be actively on duty 24/7.

Patients in mental health partial hospitalization (PHP) must be seen and treated by a psychiatrist twice weekly or more often as medically necessary. Mental health partial hospitalization clinical programming is provided at least four 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.

Patients in mental health intensive outpatient program (IOP) must be seen and treated by a psychiatrist 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 and these include crisis stabilization units and observation units. These programs offer a short focused level of care to stabilize the person for another level of care or to provide an opportunity to evaluate and refer to the most appropriate level of care.

What does Aetna expect from facilities?

Aetna expects our network facilities to meet and maintain several criteria. First, family outreach must occur within 72 hours of admission, and care must be available as clinically indicated.

For all levels of care, there must be a comprehensive assessment performed at the time of admission that includes an initial treatment plan and a tentative discharge plan. The attending psychiatrist, physician or primary therapist must contact the patient’s primary care physician with member’s consent within 48 hours of admission and at discharge as medically necessary.
What does Aetna expect from facilities?

The primary therapist must personally contact a patient’s outpatient provider within 24 hours or on the first business day of admission with consent. The outpatient provider will be made aware of the clinical treatment plan, as appropriate.

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 for completion of the diagnostic evaluation.

For all patients, discharge planning will begin at the point of admission with the expectation 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.

How is LOCAT used?

The Level of Care Assessment Tool (LOCAT) is an instrument that an Aetna clinician uses to aid in the decision-making process. The tool provides a guideline to determine the level of care appropriate for effective treatment and medically necessary for a mental health patient. “Aetna clinician” may mean a care manager, an independent physician reviewer working on Aetna’s behalf or an Aetna medical director. The LOCAT instrument does not replace clinical judgment, where a patient’s provider believes that a different level of care or course of treatment is necessary. Treating providers are solely responsible for clinical advice and treatment of patients.
For which conditions is the LOCAT used?

**Neurodevelopmental disorders**
- Intellectual disability (intellectual developmental disorder, new name for mental retardation)
- Intellectual Disability (Intellectual Developmental Disorder)
- Communication Disorders and a new condition characterized by impaired social verbal and nonverbal communication called social (pragmatic) communication disorder
- Autism Spectrum Disorder (incorporating Asperger disorder, childhood disintegrative disorder and pervasive developmental disorder not otherwise specified (PDD-NOS))
- Attention-Deficit/Hyperactivity Disorder
- Specific Learning Disorder
- Motor Disorders

**Schizophrenia spectrum and other psychotic disorders**
- Schizophrenia
- Schizophrenia subtypes
- Schizoaffective Disorder
- Delusional Disorder
- Catatonia

**Bipolar and related disorders**
- Bipolar Disorders
- Other Specified Bipolar and Related Disorder
- Anxious Distress Specifier
For which conditions is the LOCAT used?

**Depressive disorders**
- Major Depressive Disorder
- Bereavement Exclusion
- Specifiers for Depressive Disorders
- Suicidality

**Anxiety disorders**
- Agoraphobia, Specific Phobia, and Social Anxiety Disorder (Social Phobia)
- Panic Attack
- Panic Disorder and Agoraphobia
- Specific Phobia
- Social Anxiety Disorder (Social Phobia)
- Separation Anxiety Disorder
- Selective Mutism

**Obsessive-compulsive and related disorders**
- Specifiers for Obsessive-Compulsive and Related Disorders
- Body Dysmorphic Disorder
- Hoarding Disorder
- Trichotillomania (Hair-Pulling Disorder)
- Excoriation (Skin-Picking) Disorder
- Substance/Medication-Induced Obsessive-Compulsive and Related Disorder and Obsessive-Compulsive and Related Disorder Due to Another Medical Condition
- Other Specified and Unspecified Obsessive-Compulsive and Related Disorders
For which conditions is the LOCAT used?

**Trauma- and stressor-related disorders**
- Acute Stress Disorder
- Adjustment Disorders
- Posttraumatic Stress Disorder
- Reactive Attachment Disorder

**Dissociative disorders**
- Dissociative Identity Disorder

**Somatic symptom and related disorders**
- Somatic Symptom Disorder
- Medically Unexplained Symptoms
- Hypochondriasis and Illness Anxiety Disorder
- Pain Disorder
- Psychological Factors Affecting Other Medical Conditions and Factitious Disorder
- Conversion Disorder (Functional Neurological Symptom Disorder)

**Feeding and eating disorders**
- Pica and Rumination Disorder
- Avoidant/Restrictive Food Intake Disorder
- Anorexia Nervosa
- Bulimia Nervosa
- Binge-Eating Disorder
- Elimination Disorders
For which conditions is the LOCAT used?

Sleep-wake disorders
- Breathing-Related Sleep Disorders
- Circadian Rhythm Sleep-Wake Disorders
- Rapid Eye Movement Sleep Behavior Disorder
- Restless Legs Syndrome

Sexual dysfunctions
- Genito-Pelvic Pain/Penetration Disorder
- Subtypes

Gender dysphoria
- Subtypes and Specifiers

Disruptive, impulse-control, and conduct disorders
- Oppositional Defiant Disorder
- Conduct Disorder
- Intermittent Explosive Disorder

Neurocognitive disorders
- Delirium
- Major and Mild Neurocognitive Disorder
- Etiological Subtypes
- Personality Disorders

Paraphilic disorders
- Specifiers
For which conditions is the LOCAT used?

**Substance-related and addictive disorders**

- Gambling Disorder

For which behavioral health conditions is the LOCAT NOT appropriate?

- Substance use disorders (for these, the ASAM criteria are used)

What timeframe is 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 during this event that should form the basis of the Aetna clinician’s LOCAT ratings. This instrument should only be used by a clinician who has been instructed in its use. Note: The generic term *practitioner* refers to the individual outside of Aetna who is actually 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.

What components are considered?

Components that go into the 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
- Comprehensive risk assessment, including consideration of relevant demographic factors (age, ethnicity), comorbid substance use, medical conditions and support system, among other factors
ADMISSION CRITERIA:

Admission to any level of care requires an objective professional evaluation of the patient’s current condition indicating a level of severity appropriate to the requested care as evidenced by features of one or more of the following:

1. **Acute dangerousness:** Patient presents with a level of risk related to harm towards themselves through suicide, self-injury, irritability or mania; or to others through aggression, assaultive, or homicidal behavior. This dimension identifies elements of dangerousness that represent or describe a patient’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 patient’s mental health. These sub-dimensions are sensitive toward patients 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 patient. (Example: A manic patient 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 be noted in this dimension.

2. **Functional impairment:** Patient 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 work place or at school, or becoming socially isolated. 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 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.

3. **Mental status changes or co-occurring conditions:** Patient 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. A properly performed mental status examination assists a clinician in determining whether the patient 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 patient’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 patient.

4. **Psychosocial factors:** The patient’s challenges related to stress from family members, non-family members, housing, and work or school that have an impact. Trying to understand why a patient presents for treatment when he/she does is important in determining the treatment needed for that individual. Often, the patient 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.
5. **Additional modifiers:** The patient’s history of response to prior treatment, their personal resources such as intellect, characterological issues, and past history of violence or self-harm. 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 patient’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.

6. **Global indicators:** Considers other factors relevant to determining the appropriate level and type of care needed. These include whether there is a valid diagnosis causing the symptoms, and that requires professional intervention and the intensity of services needed. Patient presents at least one valid DSM-5 diagnosis not excluded by the plan, and the 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, and professional intervention is considered likely to be effective and is essential to contain risks presented and provide for improvement, and the intensity of services being provided conforms with the standards of the levels of care as defined by Aetna, and treatment at a lower level of care is not possible because the individual requires the requested level of observation and/or treatment.

**CONTINUED STAY CRITERIA:**

In order to justify remaining in any level of care, progress must be evident to show that the condition or its symptoms are treatment responsive, the patient 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. Effective planning for transition to a less restrictive level of care has begun and additional time in treatment days will reduce the probability of a re-admission to a more restrictive level of care.

**DISCHARGE CRITERIA:**

The patient is ready for discharge when they satisfy any of the following criteria:

1. They complete the planned course of treatment.
2. Their symptom intensity or impairment in functioning no longer requires the level of observation or intensity of service at the requested level of care.
3. Further professional intervention is not expected to result in significant improvement in the patient’s condition.
4. The patient leaves against medical advice (AMA).
The specificity with which the Aetna clinician obtains detailed information from the practitioner assessing the patient about the events leading to the crisis or behavior is important in determining the treatment needs. Past history, previous treatment, and review of present stressors and support systems are all required for an accurate patient assessment. The Aetna clinician is familiar with the capabilities of a local provider network to support the patient.

**INPATIENT LEVELS OF CARE** (Applies to children, adolescents, adults and older adults; all mental illness including Neurodevelopmental disorders, Schizophrenia spectrum and other psychotic disorders, Bipolar and related disorders, Depressive disorders, Anxiety disorders, Obsessive-compulsive and related disorders, Trauma- and stressor-related disorders, Dissociative disorders, Somatic symptom and related disorders, Feeding and eating disorders, Sleep-wake disorders, Sexual dysfunctions, Gender dysphoria, Disruptive, impulse-control, and conduct disorders, Neurocognitive disorders, and Paraphilic disorders; but not Substance-related and addictive disorders). Mental health inpatient must 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. A psychiatrist is available as medically necessary on a 24/7 basis.

*Acute dangerousness:* Patient presents with a level of risk related to harm towards themselves through suicide, self-injury, irritability or mania; or to others through aggression, assaultive, or homicidal behavior.

- Patient 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 patient believed that the attempt could have been lethal. The patient continues to voice a desire to die.
- Twenty-four hour medical monitoring may be necessary. In the absence of suicidality, self-inflicted attempts to hang self (for auto-erotic reasons), or other self-harm where severe injury results; medication refusal, where without the medication, the patient’s dangerous or self-injurious behavior would persist; or intravenous fluids, nasogastric tube feedings or multiple daily laboratory testing is needed.
- There are continuous thoughts about homicide with a feasible plan and intent to commit homicide. The patient has the means to complete it. 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.)

*Functional impairment:* Patient 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 work place or at school, or becoming socially isolated.

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

*Mental status changes or co-occurring conditions:* Patient 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.
Fixed delusions and the patient may act on the delusion having an effect on the patient’s or other’s safety. The patient 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 patient must be observed in a facility with round-the-clock nursing and medical coverage until the patient is medically stable. Examples of relevant conditions include: withdrawal seizures, dehydration, and lithium toxicity.

**Psychosocial factors:** The patient’s challenges related to stress from family members, non-family members, housing, and work or school that have an impact.

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 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.

**Additional modifiers:** The patient’s history of response to prior treatment, their personal resources such as intellect, characterological issues, and past history of violence or self-harm.

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 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.

**RESIDENTIAL LEVELS OF CARE** (Applies to children, adolescents, adults and older adults; all mental illness including Neurodevelopmental disorders, Schizophrenia spectrum and other psychotic disorders, Bipolar and related disorders, Depressive disorders, Anxiety disorders, Obsessive-compulsive and related disorders, Trauma- and stressor-related disorders, Dissociative disorders, Somatic symptom and related disorders, Feeding and eating disorders, Sleep-wake disorders, Sexual dysfunctions, Gender dysphoria, Disruptive, impulse-control, and conduct disorders, Neurocognitive disorders, and Paraphilic disorders; but not Substance-related and addictive disorders). Mental Health residential care must be under the care of an attending psychiatrist, and members must be treated by a Psychiatrist at least once per week. A licensed behavioral health professional must be actively on duty 24/7

**Acute dangerousness:** Patient presents with a level of risk related to harm towards themselves through suicide, self-injury, irritability or mania; or to others through aggression, assaultive, or homicidal behavior.

Suicidal plan and intent, but without organized means to execute the plan. The patient is able to develop a plan for safety with some reservations or conditions (only in a facility, etc.), or the patient 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 patient is now able to develop a plan for safety with some reservations or conditions (only in a facility, for example), or the patient is not able to contract for safety but is well known to the practitioner/evaluator and is not believed to be at serious risk. 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. Behavior that demonstrates impaired judgment to the extent that serious harm or death may
result (for example, a patient 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 patient needs direct supervision to comply with medication or meals).

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

**Functional impairment:** Patient 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 work place or at school, or becoming socially isolated.

Appetite disturbances have resulted in significant (20 lb. or more for an adult) weight gain or loss over the last month. The patient is engaging in restricting, binging 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. Patient fired, expelled and unable to work/attend school due to mental status. An inability to obtain basic needs (such as food, shelter, medical care) due to mental illness.

**Mental status changes or co-occurring conditions:** Patient 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.

Patient 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 patient’s delusions are so pervasive that most waking moments are spent in the delusional system, thus rendering the patient inaccessible to verbal interventions. Command hallucinations, and the patient 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. Patient with substance use, who becomes suicidal, homicidal or assaultive when under the influence. The patient has a potentially lethal medical condition that is related to substance use. The patient has a serious psychiatric condition with a medical condition that requires ongoing medical attention (for example, intramuscular medications, patient refuses life-sustaining medications, etc.).

**Psychosocial factors:** The patient’s challenges related to stress from family members, non-family members, housing, and work or school that have an impact.

Patient has transient housing. Recent extreme violence at work or school toward the patient. No support is available. The patient is alone without family and/or significant agency support, or the patient does not choose to utilize the available support system. Getting food or housing may be a problem.

**Additional modifiers:** The patient’s history of response to prior treatment, their personal resources such as intellect, characterological issues, and past history of violence or self-harm.
Remains treatment refractory despite multiple trials of optimal interventions in higher levels of care. Actively sabotages treatment; refuses to participate in treatment. Physical violence perpetrated by the patient with the use of implements or weapons (knife, gun, bat, scissors, etc.) has occurred.

**PARTIAL HOSPITALIZATION LEVEL OF CARE** (Applies to children, adolescents, adults and older adults; all mental illness including Neurodevelopmental disorders, Schizophrenia spectrum and other psychotic disorders, Bipolar and related disorders, Depressive disorders, Anxiety disorders, Obsessive-compulsive and related disorders, Trauma- and stressor-related disorders, Dissociative disorders, Somatic symptom and related disorders, Feeding and eating disorders, Sleep-wake disorders, Sexual dysfunctions, Gender dysphoria, Disruptive, impulse-control, and conduct disorders, Neurocognitive disorders, and Paraphilic disorders; but not Substance-related and addictive disorders). Patient in mental health partial hospitalization must be seen and treated by a psychiatrist twice weekly or more often as medically necessary. Mental health partial hospitalization clinical programming is provided at least four 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.

**Acute dangerousness:** Patient presents with a level of risk related to harm towards themselves through suicide, self-injury, irritability or mania; or to others through aggression, assaultive, or homicidal behavior.

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; patient may have continued thoughts but no plan or intent. Patient is able to develop a safety plan without reservation. 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.

Homicidal thoughts may be fleeting or persistent, and the patient 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. Behavior evidencing disorganized thought processes or inability to engage appropriately in social interactions.

**Functional impairment:** Patient 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 work place or at school, or becoming socially isolated.

Withdrawal from most situations, including social and occupational/educational. Patient 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.
**Mental status changes or co-occurring conditions:** Patient 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.

Malodorous: patient 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 patient’s functioning is affected. Not oriented to time or place. Psychomotor agitation or psychomotor retardation. Auditory, and/or visual hallucinations. A patient who becomes suicidal, homicidal, assaultive or psychotic when under the influence. (The suicidality, homicidality and/or the psychosis are clearly related to the substance).

**Psychosocial factors:** The patient’s challenges related to stress from family members, non-family members, housing, and work or school that have an impact.

Recent extreme violence directed towards the patient from neighbors or peers, current or recent physical or sexual abuse by a non-family member. The patient is awaiting placement (foster home, residential school, CRR, etc.), or the patient has lost his/her place to live but has the means to secure an alternative residence. Recent expulsion from school for any reason, or greater than 20 unexcused absences this academic year; or forced unemployment.

**Additional modifiers:** The patient’s history of response to prior treatment, their personal resources such as intellect, characterological issues, and past history of violence or self-harm.

Serious and disabling symptoms remain despite adequate treatment; failure to return to previous baseline level of functioning, despite adherence to treatment. There is a prior history of the patient losing control of anger, rage or aggressive thoughts and becoming violent, or there has been a history of prior suicide attempts by the patient 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 patient believed that the attempt could have been lethal.

**INTENSIVE OUTPATIENT LEVEL OF CARE** (Applies to children, adolescents, adults and older adults; all mental illness including Neurodevelopmental disorders, Schizophrenia spectrum and other psychotic disorders, Bipolar and related disorders, Depressive disorders, Anxiety disorders, Obsessive-compulsive and related disorders, Trauma- and stressor-related disorders, Dissociative disorders, Somatic symptom and related disorders, Feeding and eating disorders, Sleep-wake disorders, Sexual dysfunctions, Gender dysphoria, Disruptive, impulse-control, and conduct disorders, Neurocognitive disorders, and Paraphilic disorders; but not Substance-related and addictive disorders). Members in mental health intensive outpatient programs must be seen and treated by a psychiatrist 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.

**Acute dangerousness:** Patient presents with a level of risk related to harm towards themselves through suicide, self-injury, irritability or mania; or to others through aggression, assaultive, or homicidal behavior.
Fleeting thoughts of suicide, but no plan, intent or actions. Fleeting is defined as occasional thoughts that do not persist most days. Where medical intervention is typically not warranted. Self-inflicted scratches or abrasions, hair pulling, hitting self, or otherwise causing self-harm. For those with an eating disorder, a pattern of restricting, binging 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. 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.

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

**Functional impairment:** Patient 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 work place or at school, or becoming socially isolated.

Social withdrawal, or limited range of social contacts or interactions (in comparison to baseline). The Member may withdraw from some social situations. The patient’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 patient is engaging in restricting, binging 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.

**Mental status changes or co-occurring conditions:** Patient 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.

Unkempt: patient is performing hygiene activities needed to maintain physical health but not at the premorbid baseline expected for this patient. 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 patient at baseline). Affect not appropriate to content of discussion. Patient admits to hazardous alcohol and/or substance use. The patient describes a history of substance-induced amnesia (blackouts). Known medical problems do not or moderately interfere with routine psychiatric care of the patient, 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.

**Psychosocial factors:** The patient’s challenges related to stress from family members, non-family members, housing, and work or school that have an impact.

Serious illness of a family member; disruption of a family by separation, divorce, or estrangement; substance abuse/dependence in a family member. Patient 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. Removal (placement) of the patient out of the home, current or recent physical or sexual abuse by a family member, recent death of an immediate family member.
Additional modifiers: The patient’s history of response to prior treatment, their personal resources such as intellect, characterological issues, and past history of violence or self-harm.

There have been treatment failures, rapid recurrences of symptoms or only partial remission of symptoms. The patient 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 patient 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.

OUTPATIENT LEVEL OF CARE (Applies to children, adolescents, adults and older adults; all mental illness including Neurodevelopmental disorders, Schizophrenia spectrum and other psychotic disorders, Bipolar and related disorders, Depressive disorders, Anxiety disorders, Obsessive-compulsive and related disorders, Trauma- and stressor-related disorders, Dissociative disorders, Somatic symptom and related disorders, Feeding and eating disorders, Sleep-wake disorders, Sexual dysfunctions, Gender dysphoria, Disruptive, impulse-control, and conduct disorders, Neurocognitive disorders, and Paraphilic disorders; but not Substance-related and addictive disorders).

Acute dangerousness: Patient presents with a level of risk related to harm towards themselves through suicide, self-injury, irritability or mania; or to others through aggression, assaultive, or homicidal behavior.

Fleeting thoughts of suicide, but no plan, intent or actions. Fleeting is defined as occasional thoughts that do not persist most days.
Where medical intervention is typically not warranted. Self-inflicted scratches or abrasions, hair pulling, hitting self, or otherwise causing self-harm. For those with an eating disorder, a pattern of restricting, binging 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.
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.
Hypomania, or occasional inappropriate arguments with other people, without physical violence

Functional impairment: Patient 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 work place or at school, or becoming socially isolated.

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.). Patient identifies stress at school or work and has difficulty performing responsibilities due to poor concentration or anxiety, without related absenteeism.

Mental status changes or co-occurring conditions: Patient 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.
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 patient 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 patient presents with psychiatric signs and symptoms that may be due to a medical illness, (therefore a medical work-up is indicated) and/or there are known medical problems that do not interfere with routine psychiatric care of the patient.

**Psychosocial factors:** The patient’s challenges related to stress from family members, non-family members, housing, and work or school that have an impact.

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. Patient has a place to live, but it is substandard and/or lives in a high-crime and/or high-drug area. Declining grades and/or frequent unexcused absences from school or work (less 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 patient and/or toward the patient’s recovery, and/or financial resources as it relates to getting care may be a problem.

**Additional modifiers:** The patient’s history of response to prior treatment, their personal resources such as intellect, characterological issues, and past history of violence or self-harm.

There is a history of symptom remission but not sustained, or a history of symptom recurrences. The patient is ambivalent about treatment, personality factors (self-defeating characteristics, for example) may impact effort towards 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 consequences for the relative).

**HOW DOES LOCAT COMPARE TO OTHER CRITERIA?**


Section 72 of the Act amends section 38a-591c of the Connecticut General Statutes and requires that for any utilization review or benefit determination for treating a substance use disorder or mental disorder, carriers must use the default criteria set forth in the Act. In the alternative, carriers may use other criteria that it demonstrates are consistent with the default criteria.
This document demonstrates that Aetna’s utilization review and benefit determination criteria are consistent with the default criteria by comparing each aspect of Aetna’s criteria with the default criteria. The comparison document explains any differences between the default criteria and Aetna’s criteria, concluding that there are no significant clinical deviations.

For purposes of utilization reviews or benefit determinations for treating substance abuse disorder, Aetna uses the default criteria (the most recent edition of the American Society of Addiction Medicine’s Criteria or “ASAM Criteria”). Therefore, no comparison is necessary.

For utilization review or benefit determination for treating mental health disorders in a child, adolescent or adult, Aetna uses Aetna’s Level of Care Assessment Tool (“LOCAT”). As shown below, LOCAT is consistent with default criteria (i.e., the most recent guidelines in the American Academy of Child and Adolescent Psychiatry's Child and Adolescent Service Intensity Instrument as well as the most recent guidelines of the American Psychiatric Association).

The Aetna Level Of Care Assessment Tool (LOCAT):


Comparison of LOCAT and the American Academy of Child and Adolescent Psychiatry’s Child and Adolescent Service Intensity Instrument (CASII)

<table>
<thead>
<tr>
<th>Feature</th>
<th>The Aetna Level of Care Assessment Tool (LOCAT)</th>
<th>American Academy of Child and Adolescent Psychiatry's Child and Adolescent Service Intensity Instrument (CASII)</th>
<th>Explanations of Differences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age range</td>
<td>The LOCAT can be utilized to assess members of all ages, and specifically includes data points relevant to children and adolescents.</td>
<td>The CASII criteria are specific to children and adolescents.</td>
<td>LOCAT can be used with children and adolescents; these are clinically equivalent. No deviation.</td>
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<tr>
<td>Uses</td>
<td>The LOCAT is used to guide determinations for inpatient, residential, partial hospitalization, intensive outpatient and routine outpatient treatment. Information from a telephonic interview, record review and any additional documentation is used to make the determination.</td>
<td>The CASII is a tool to quantify the clinical severity and service needs of children and adolescents with psychiatric disorders, substance use disorders, or developmental disorders, and can integrate these as overlapping clinical issues.</td>
<td>LOCAT is used as a guideline to help determine the appropriate levels and types of care for patients in need of evaluation and treatment for behavioral health symptoms and diagnoses. Use of the LOCAT results in consideration of severity of psychiatric disorders, substance use disorders, or developmental disorders, and can integrate these as overlapping clinical issues. No deviation.</td>
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<tr>
<td>Revisions</td>
<td>The LOCAT is assessed annually. Clinical review and professional input is obtained externally from providers and academics. Internal users of the tool also have the opportunity to provide feedback and suggest improvements.</td>
<td>There have been no recent clinical revisions of CASII. The last clinical revision was in 2001. (There was a 2010 update to the manual and language.)</td>
<td>Factual difference results in no deviation.</td>
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<tr>
<td>Sponsor</td>
<td>The LOCAT was developed and has been revised by Aetna for use by Aetna clinicians to assist as a guideline in making level of care determinations.</td>
<td>The CASII was developed by the American Academy of Child and Adolescent Psychiatry and the American Association of Community Psychiatrists.</td>
<td>Factual difference results in no deviation.</td>
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<tr>
<td>Levels of care</td>
<td>The LOCAT is used to guide clinical placement determinations for inpatient, residential, partial hospitalization, intensive outpatient and routine outpatient treatment.</td>
<td>Levels of care are defined by intensity of service according to crisis, support, clinical and environmental factors.</td>
<td>According to the principles of CASII: “It will not prescribe program design, but rather the type and intensity of resources that need to be available in that program.” Aetna’s network provider contracts specify intensity of service at each level of care. No deviation.</td>
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<tr>
<td>Organization</td>
<td>The LOCAT contains six areas of concern or “dimensions” These five dimensions are: Dangerousness, Functional Impairment, Mental Status/Comorbid Factors, Psychosocial Factors, Additional Modifiers and Global Indicators. Each dimension contains sub-dimensions that are evaluated according to anchor points along a continuum of symptoms with increasing degrees of clinical significance.</td>
<td>The CASII dimensional rating system is used to determine the intensity of a child or adolescent’s service needs. Each dimension has a 5-point rating scale, from least to most severe, each with a clearly defined set of criteria. Only one criterion needs to be met for that rating to be selected. Therefore, for each dimension, the highest rating in which at least one of the criteria is met is the rating that should be assigned.</td>
<td>Sections are organized in a different format, but these are substantially similar in that with LOCAT, the level of care corresponds to the most significant symptoms. No deviation.</td>
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<td>Purpose</td>
<td>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.</td>
<td>CASII employs multi-disciplinary/multi-informant perspectives on children and adolescents to be used by mental health professionals. It is primarily used for initial level of care placement decisions but can be used at all stages of treatment to assess the level of care.</td>
<td>Similar to CASII, LOCAT can accommodate input from multiple informants and at various points in treatment. Both tools are used to distinguish between levels of care. No deviation.</td>
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<tr>
<td>Dimensional Assessment</td>
<td>Dimension 1 Dangerousness</td>
<td>Dimension I Risk of Harm</td>
<td>LOCAT is more comprehensive in specifying additional risk factors for a child or adolescent, including disordered eating, refusal of medication or other treatment, irritability, aggression, threats of harm towards others and mania. Potential for being the victim of abuse, neglect or violence is found in LOCAT Dimension 4, Psychosocial Factors. No deviation.</td>
</tr>
<tr>
<td><strong>Dimension 1 Dangerousness</strong></td>
<td>This dimension identifies elements of dangerousness that represent or describe a patient’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 ensure that a more complete clinical picture of a patient is available. These sub-dimensions are sensitive toward patients 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 patient. (Example: A manic patient 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 be scored using this dimension.</td>
<td>This dimension is the measurement of a child or adolescent’s risk of self-harm by various means and an assessment of his/her potential for being a victim of physical or sexual abuse, neglect or violence; rated according to a 5-point scale.</td>
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<td><strong>Dimension 2 Functional Impairment</strong></td>
<td>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/her in the environment. Implied in this dimension is the notion that the patient’s level of functioning may have changed from the previous baseline level of functioning. The evaluator needs to explore the previous baseline level of functioning, and the possibility of</td>
<td>This dimension measures the impact of a child or adolescent’s primary condition daily life; assesses ability to function in all age-appropriate roles; assesses the effect the primary problem on basic daily activities; rated on a 5-point scale.</td>
<td>No deviation.</td>
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<td>concurrent chemical dependency that may contribute to or explain the functional impairment. The Functional Impairment dimension includes consideration of social isolation, nutritional impairment, sleep disturbance, and school or work impairment.</td>
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<td><strong>Dimension 3 Mental Status/Comorbid Factors</strong></td>
<td><strong>Dimension III Co-morbidity</strong></td>
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<td>This dimension addresses multiple factors that need to be taken into consideration when making a level of care determination. A properly performed mental status examination assists the clinician in determining whether the patient is psychotic. Psychosis is a key factor in determining the appropriate level of care. This sub-dimension measures current psychological functioning using selected components of a mental status examination. Alcohol and substance abuse in a patient can also dramatically complicate and change the necessary level of care. In many cases, psychiatric conditions co-exist with significant medical conditions. This sub-dimension underscores the need for a close working relationship between the medical caregivers and the 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.</td>
<td>This dimension assesses the co-existence of developmental disability, medical condition(s), substance abuse, and psychiatric condition(s); rated on a 5-point scale.</td>
<td>LOCAT requires greater specificity and requires consideration of multiple relevant factors. No deviation.</td>
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<td><strong>Dimension 4 Psychosocial Factors</strong></td>
<td><strong>Dimension IV Recovery environment</strong></td>
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<td>This dimension addresses the fact that it is important to understand why a patient presents</td>
<td>Divided into two sub-scales: environmental stress and environmental support. Includes</td>
<td>No deviation.</td>
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<td>for treatment when he/she does. Often, the patient or his/her family can identify the 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 and most competent practitioners spend time exploring these resources. In making a level of care decision, this should be taken into account. The Psychosocial Factors include:</td>
<td>factors in the environment that may contribute to the onset or maintenance of addiction or mental illness; each is rated on a 5-point scale.</td>
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<td>● Family /non-family stressors</td>
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<td>● Housing</td>
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<td>● School or work environment</td>
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<td>● General level of supports</td>
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<td>Dimension 5 Additional Modifiers</td>
<td>Dimension V Resiliency and Treatment History</td>
<td>LOCAT contains ratings for past treatment history and additional factors such as health literacy, personality factors, logistical barriers and past history of dangerous actions. No deviation.</td>
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<tr>
<td>This LOCAT dimension was created to address clinical factors that have not yet been taken into consideration. The additional modifiers include treatment history, personal resources, and history of dangerous behaviors.</td>
<td>This dimension measures the patient’s resiliency and how the patient and family have responded to past treatment. This dimension assesses a patient’s ability to respond to a treatment environment; rated on a 5-point scale.</td>
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<tr>
<td>Dimension 6 Global Indicators</td>
<td>Dimension VI Acceptance and Engagement</td>
<td>LOCAT contains these factors in other sections: the support system (including family’s acceptance and engagement under Dimension 4, engagement and resistance to treatment in Dimension 5. No deviation.</td>
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<td>This dimension considers whether there is a valid DSM-5 diagnosis, whether there are interventions likely to be effective, and the intensity of services.</td>
<td>This dimension has two sub-dimensions which measure the patient’s and family’s acceptance and engagement; rated on a 5-point scale. Only the highest sub-dimension score is used in calculating the composite score.</td>
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<tr>
<td>Definitions of Levels of Care</td>
<td>LOCAT addresses five levels of care based on the dimensions and sub-dimensions. The specific</td>
<td>CASII describes preventive services which are covered without the need for clinical</td>
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<tr>
<td>Feature</td>
<td>The Aetna Level of Care Assessment Tool (LOCAT)</td>
<td>American Academy of Child and Adolescent Psychiatry's Child and Adolescent Service Intensity Instrument (CASII)</td>
<td>Explanations of Differences</td>
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<td>definitions are as follows:</td>
<td>Mental health <strong>inpatient</strong> must 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 treatment record. In addition a psychiatrist must be available on a 24/7 basis.</td>
<td>Prevention Services, and Care Environment) to define the following levels of care:</td>
<td>review. LOCAT describes the same levels of care as CASII levels two through six. Requirement are in the tool related to intensity of monitoring and this is also accomplished through network contracts, credentialing and state licensure of the facilities as applicable. No deviation.</td>
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<tr>
<td>Mental Health <strong>residential (RTC)</strong> care must be under the care of an</td>
<td>Medication management, Psychotherapy, Pharmacotherapy, Consultation, Case Management, Care Coordination, Education</td>
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<td>attending psychiatrist with documented treatment by a psychiatrist at</td>
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<td>least once per week, or more often as medically necessary. A licensed</td>
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<td>behavioral health professional (example, psychiatrist, psychologist,</td>
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<td>licensed social worker) must be on-site and actively on duty 24 hours</td>
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<td>a day, 7 days a week.</td>
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<td>Members in mental health <strong>partial hospitalization (PHP)</strong> must be seen</td>
<td>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.</td>
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<td>and treated by a psychiatrist (with care documented) twice weekly or</td>
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<td>more often as medically necessary.</td>
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<td>Members in mental health <strong>intensive outpatient program (IOP)</strong> must</td>
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<td>be seen and treated by a psychiatrist (with care documented) as medically</td>
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<td>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 and these include <strong>crisis stabilization</strong> units and <strong>observation</strong> 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.</td>
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<tr>
<td>Scoring</td>
<td>The recommended level of care is determined by considering all six dimensions (Dangerousness, Functional Impairment, Mental Status/Comorbid Factors, Psychosocial Factors, Additional Modifiers and Global Indicators). These then guide the clinician in making the actual level of care determination.</td>
<td>CASII utilizes a Decision Tree and Level of Care Determination grid.</td>
<td>No deviation.</td>
</tr>
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</table>

**Comparison of LOCAT and the American Psychiatric Association’s (APA) Criteria for Short-Term Treatment of Acute Psychiatric Illness**

Both LOCAT and the APA Criteria make it clear that the criteria do not replace clinical judgment.

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 LOCAT instrument does not replace clinical judgment, where a provider believes that a different level of care or course of treatment is necessary. Treating providers are solely responsible for clinical advice and treatment of members.

Similarly, as stated in the APA criteria, the criteria provide a guideline for evaluating medical necessity and should not be interpreted to be absolute rules for determining the level of care required by a patient.

Clinical judgment is as important as any factor outlined in this document.

<table>
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<tr>
<th>Feature</th>
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<th>American Psychiatric Association's Criteria for Short-Term Treatment of Acute Psychiatric Illness</th>
<th>Explanations of Differences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age range</td>
<td>The LOCAT criteria can be utilized to assess members of all ages.</td>
<td>Criteria For Short-Term Treatment of Acute Psychiatric Illness, is a 1996 revision of an American Academy of Child &amp; Adolescent Psychiatry (AACAP) document that was produced jointly by AACAP and the American Psychiatric Association (APA). These criteria can be utilized to assess adults, children and adolescents.</td>
<td>No difference in age groups between the tools. No deviation.</td>
</tr>
<tr>
<td>Uses</td>
<td>The LOCAT items are used to guide determinations for inpatient, residential, partial hospitalization, intensive outpatient and routine outpatient treatment. Information from a telephonic interview, record review and any additional documentation is used to make the determination.</td>
<td>The criteria provide a guideline for evaluating medical necessity for levels of care for short-term treatment of acute psychiatric illness. According to the introduction to the criteria, they should not be interpreted to be absolute rules for determining the level of care required by a patient; clinical judgment is as important as any factor outlined in this document.</td>
<td>The Level of Care Assessment Tool (LOCAT) is a clinical, evidence-based instrument developed by Aetna for behavioral health patient management. The LOCAT is utilized to guide and track level of care decisions for Aetna members in need of behavioral health services. This tool also serves to improve and standardize data collection and documentation for Aetna's behavioral health precertification and concurrent review services. No deviation.</td>
</tr>
<tr>
<td>Revisions</td>
<td>The LOCAT is updated annually. Clinical review and professional input is obtained externally from providers and academics. A detailed literature</td>
<td>This criteria set has not been revised since 1997, but was reviewed in 2011 with no changes made. (APA website)</td>
<td>Factual difference results in no deviation.</td>
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<tr>
<td>Sponsor</td>
<td>LOCAT was developed by Aetna for use by Aetna clinicians to assist in making level of care determinations.</td>
<td>A joint publication of the American Academy of Child &amp; Adolescent Psychiatry and the American Psychiatric Association.</td>
<td>Factual difference results in no deviation.</td>
</tr>
<tr>
<td>Levels of care</td>
<td>The LOCAT items are used to guide clinical placement determinations for inpatient, residential, partial hospitalization, intensive outpatient and routine outpatient treatment.</td>
<td>Covers only the most frequently utilized settings: acute inpatient hospitalization; medically supervised, psychiatric residential treatment; acute partial hospitalization; intensive outpatient treatment; outpatient treatment</td>
<td>LOCAT’s anchor points were set to err very conservatively in the direction of safety, that is, avoidance of any underutilization of higher levels of care, with the caveat that LOCAT cannot be used as the prime or sole determinant of levels of care. The levels of care listed by the APA criteria correspond to the levels of care within the Aetna network of facilities. No deviation.</td>
</tr>
<tr>
<td>Organization</td>
<td>The LOCAT contains six areas to be considered called “dimensions” These six dimensions are: Dangerousness, Functional Impairment, Mental Status and Comorbid Factors, Psychosocial Factors, Additional Modifiers and Global Indicators. Each dimension contains sub-dimensions with anchor points along a continuum of symptoms with increasing degrees of clinical significance used to guide the determination.</td>
<td>These following factors, along with the severity of the presenting problems, modify decision making in regard to determining the level of care required for a particular patient. 1. Comorbid psychiatric conditions; 2. Comorbid substance abuse conditions; 3. Comorbid biomedical conditions; 4. The patient’s acceptance or resistance to treatment; 5. The level of support from the family and other environmental factors; and 6. The persistence of the disease process and the likelihood for relapse.</td>
<td>All of the factors in the APA criteria are contained within the LOCAT. Each has a separate section so that detailed consideration of these factors is required. No deviation.</td>
</tr>
<tr>
<td>Purpose</td>
<td>The Level of Care Assessment Tool (LOCAT) is an</td>
<td>According to the document, these criteria</td>
<td>LOCAT was designed as a guideline with</td>
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<td>instrument that an Aetna clinician uses to aid in the decision-making process that determines the level of care appropriate for effective treatment and medically necessary for a patient. It is used by trained Aetna clinicians (Aetna care managers, an independent physician reviewer working on Aetna’s behalf or an Aetna medical director.)</td>
<td>should lead to more effective communication between managed care companies and clinicians and, most importantly, to improved treatment planning.</td>
<td>emphasis on comprehensive clinical data gathering. All training emphasizes that it should be over-ridden when there is conflict between care suggested by it and sound clinical judgment. Explicitly stated in LOCAT: Aetna’s assessment of medical necessity (using LOCAT or otherwise) is not intended to supplant or modify a treating practitioner’s recommendations as to the necessary level of care or course of treatment. 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. This is equivalent to the APA document: The criteria provide a guideline for evaluating medical necessity and should not be interpreted to be absolute rules for determining the level of care required by a patient. Clinical judgment is as important as any factor outlined in this document. No deviation.</td>
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<tr>
<th>Dimension 1</th>
<th>Dangerousness</th>
<th>No equivalent APA section</th>
<th>LOCAT is more detailed and considers more factors. No deviation.</th>
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<td>This dimension identifies elements of dangerousness that represent or describe a patient’s behavior. To evaluate dangerousness, the mental health practitioner usually assesses suicidal intent and homicidal intent. However, the</td>
<td>Must satisfy the following, with a DSM-IV diagnosis as the basis for risk: Imminent risk for self-injury, with an inability to guarantee safety. Imminent risk for injury to others.</td>
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<p>| 37 |</p>
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<td>additional sub-dimensions of self-injuriousness and irritability/aggression/ mania help ensure that a more complete clinical picture of a patient is available. These sub-dimensions are sensitive toward patients 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 patient. (Example: A manic patient 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 be scored using this dimension. This dimension includes sub-dimensions of suicidal intent, self-injuriousness, homicidal intent and irritability/aggression/mania. Each sub-dimension lists examples (including symptoms of an eating disorder, medication refusal and prior actions) that represent anchor points along a continuum of symptoms with increasing degrees of clinical significance. The Aetna clinician uses these descriptions to aid in the decision-making process that determines the medically necessary level of care appropriate for effective treatment.</td>
<td>There is an active psychiatric disorder. Acute and serious deterioration from the patient’s baseline ability to fulfill age-appropriate responsibilities. Imminent risk for acute medical status deterioration due to the presence and/or treatment of an active psychiatric symptom. Weight loss to a point that the patient is 15% below ideal weight.</td>
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<tr>
<td>Dimension 2</td>
<td>Functional Impairment</td>
<td>No equivalent APA section</td>
<td>LOCAT is more detailed and considers more factors. No deviation.</td>
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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/her in the environment. Implied in this dimension is the notion that the patient’s level...
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<tr>
<td>Dimension 3</td>
<td>Mental Status/Comorbid Factors</td>
<td>No equivalent APA section</td>
<td>LOCAT is more detailed and considers more factors. No deviation.</td>
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<td>of functioning may have changed from the previous baseline level of functioning. The evaluator needs to explore the previous baseline level of functioning, and the possibility of concurrent chemical dependency that may contribute to or explain the functional impairment. The Functional Impairment dimension includes social isolation, nutritional impairment, sleep disturbance, and school or work impairment.</td>
<td>• Family and/or Social/peer relations To the extent that behavior is so disordered, disorganized, or bizarre that it would be unsafe for the patient to be treated in a lesser level of care.</td>
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<td>Dimension 4</td>
<td>Psychosocial Factors</td>
<td>No equivalent APA section</td>
<td>LOCAT is more detailed and considers more factors. No deviation.</td>
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<td>This dimension addresses multiple factors that need to be taken into consideration when making a level of care determination. A properly performed mental status examination assists the clinician in determining whether the patient 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. Alcohol and substance abuse in a patient can also dramatically complicate and change the necessary level of care. In many cases psychiatric conditions co-exist with significant medical conditions.</td>
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<td>these resources. In making a level of care decision, this should be taken into account. The Psychosocial Factors include family and non-family stressors, housing, school or work environment, and general level of supports.</td>
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<td>Dimension 5</td>
<td><strong>Additional Modifiers</strong></td>
<td>No equivalent APA section</td>
<td>LOCAT is more detailed and considers more factors. No deviation.</td>
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<tr>
<td>This LOCAT dimension was created to address clinical factors that have not yet been taken into consideration. The additional modifiers sub-dimensions include treatment history, personal resources, and history of dangerous behaviors. Included are factors such as such as health literacy, personality factors, logistical barriers and past history of dangerous actions.</td>
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<tr>
<td>Definitions of Levels of Care</td>
<td>LOCAT addresses five levels of care based on the dimensions and sub-dimensions described above. The specific definitions are as follows: Mental health <strong>inpatient</strong> must 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 treatment record. In addition a psychiatrist must be available on a 24/7 basis.</td>
<td>APA defines five levels of care as follows: <strong>Acute inpatient hospitalization:</strong> treatment that includes 24-hour nursing and daily, active treatment under the direction of a psychiatrist, or for children and adolescents, a board certified/eligible child and adolescent psychiatrist. Must satisfy the following, with a DSM-IV diagnosis the basis for risk: Imminent risk for self-injury, with an inability to guarantee safety. Imminent risk for injury to others. There is an active psychiatric disorder. Acute and serious deterioration from the</td>
<td>LOCAT describes the same levels of care as the APA criteria. The requirement related to intensity of monitoring is also accomplished through network contracts (modeled on industry standards and based on APA definitions of levels of care), credentialing, quality management and oversight activities by Aetna, and state licensure of the facilities as applicable. LOCAT is more detailed and in addition to those factors listed by the APA, considers more factors, while representing significant overlap with the APA criteria. No deviation.</td>
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| Mental Health **residential (RTC)** care must 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. | patient’s baseline ability to fulfill age-appropriate responsibilities in one or more of the following areas:  
- Education;  
- Vocation;  
- Family; and/or  
- Social/peer relations;  
to the extent that behavior is so disordered, disorganized, or bizarre that it would be unsafe for the patient to be treated in a lesser level of care.  
Imminent risk for acute medical status deterioration due to the presence and/or treatment of an active psychiatric symptom.  
Weight loss to a point that the patient is 15% below ideal weight. | LOCAT describes the same levels of care as the APA criteria. The requirement related to intensity of monitoring is also accomplished through network contracts (modeled on industry standards and based on APA definitions of levels of care), credentialing, quality management and oversight activities by Aetna, and state licensure of the facilities as applicable. LOCAT is more detailed and in addition to those factors listed by the APA, considers more factors, while representing significant overlap with the APA criteria. No deviation. |
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<td>Patients in mental health partial hospitalization (PHP) must 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.</td>
<td>Acute partial hospitalization: treatment that includes daily nursing and active treatment in a structured treatment program lasting 5–7 days per week and delivering at least 20 hours of active treatment per week, with patients going home each evening and/or weekend. Acute and serious impairment of psychosocial functioning (and/or in the case of children, developmental progression) from the patient’s baseline due to a DSM-IV psychiatric disorder in one or more of the following areas: - Family; and/or - Social/peer relations. The patient’s behaviors resulting from such a psychiatric disorder require a supervised, structured, and 24-hour continuous therapeutic milieu for effective treatment to occur. Refractory to an adequate trial of, or clearly inappropriate for, active treatment at a lesser level of care.</td>
<td>LOCAT describes the same levels of care as the APA criteria. The requirement related to intensity of monitoring is also accomplished through network contracts (modeled on industry standards and based on APA definitions of levels of care), credentialing, quality management and oversight activities by Aetna, and state licensure of the facilities as applicable. LOCAT is more detailed and in addition to those factors listed by the APA, considers more factors, while representing significant overlap with the APA criteria. No deviation.</td>
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<td>• Social/peer relations.</td>
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<td>Refractory to an adequate trial of, or clearly inappropriate for, active treatment at a lesser level of care.</td>
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<td>The severity of the psychiatric disorder and the impairment of developmental progression and/or psychosocial functioning from the disorder have been demonstrated to require a supervised, structured, and supportive therapeutic milieu, with the goal of improving adaptive functioning and returning to a developmentally and culturally appropriate social role in school, work, home, etc.</td>
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<td>Symptoms and history do not meet the criteria for acute inpatient hospitalization and do not require a 24-hour, continuous, structured therapeutic milieu.</td>
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<td>The patient must have an acceptably safe and stable living environment when s/he is not at the program. For patients with special dependency needs (e.g., children, adolescents, individuals who are seriously medically or physically impaired), that environment is provided by families, guardians, and/or appropriate social support systems.</td>
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<td>The patient demonstrates an intent to form a treatment alliance and comply with treatment.</td>
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<td>Patients in mental health intensive outpatient program (IOP) must 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.</td>
<td>Intensive outpatient treatment: a structured program that includes combinations of individual and group process therapy, meeting at least three times per week, and delivering at least 4 hours of treatment per week. Outpatient treatment (general): a level of care in which patients are seen by one or more clinicians as individuals, part of their families, or part of a group. Must satisfy each of the following: An acute behavioral and/or emotional crisis due to a DSM-IV psychiatric disorder, manifested by a risk for self-injury, injury to others, destruction of property, or deterioration in ability to fulfill age-appropriate responsibilities. Refractory to an adequate trial of, or clearly inappropriate for, active treatment at a lesser level of care. There is a reasonable expectation that the patient will form a treatment alliance. The patient has sufficient family and/or social resources that have expressed a willingness to provide support for psychiatric treatment, or failing that, a supportive environment that can be identified for that purpose.</td>
<td>LOCAT describes the same levels of care as the APA criteria. The requirement related to intensity of monitoring is also accomplished through network contracts (modeled on industry standards and based on APA definitions of levels of care), credentialing, quality management and oversight activities by Aetna, and state licensure of the facilities as applicable. LOCAT is more detailed and in addition to those factors listed by the APA, considers more factors, while representing significant overlap with the APA criteria. No deviation.</td>
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<td>Scoring</td>
<td>The recommended level of care is determined by considering all six dimensions (Dangerousness, Functional Impairment, Mental Status/Comorbid Factors, Psychosocial Factors, Additional Modifiers)</td>
<td>The APA guidelines list out specific clinical factors that must be present in order to meet admission standards for each specific level of care.</td>
<td>LOCAT is more detailed and considers more factors. No deviation.</td>
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</table>
### Comparison of LOCAT and the Standards and Guidelines of the Association of Ambulatory Behavioral Healthcare ("AABH")

The Continuum of Ambulatory Behavioral Healthcare Services — Service Variables

<table>
<thead>
<tr>
<th>Service Examples</th>
<th>Ambulatory Level One</th>
<th>Ambulatory Level Two</th>
<th>Ambulatory Level Three</th>
<th>Corresponding LOCAT Feature</th>
</tr>
</thead>
</table>
|                  | • Partial Hospitalization Programs  
                   • Day Treatment Programs  
                   • Intensive In-Home Crisis Intervention  
                   • Outpatient Detoxification Services | • Psycho-Social Rehabilitation  
                   • Intensive Outpatient Programs  
                   • Behavioral Aides  
                   • Assertive Community Treatment  
                   • 23-Hour Observation Beds | • 23-Hour Respite Beds  
                   • Multi-modal Outpatient Services  
                   • Aftercare  
                   • Clubhouse Programs  
                   • In-Home Services | LOCAT describes the same levels of care as the AABH level one and level two ambulatory services. No deviation.  
The level one and level two requirements are consistent with Aetna’s network contracts (modeled on industry standards and based on APA definitions of levels of care). Most Aetna plans do not provide coverage for level three services.  
Coverage for outpatient (ambulatory) detoxification services is managed using ASAM criteria. No deviation. |
<table>
<thead>
<tr>
<th>Service Function</th>
<th>Ambulatory Level One</th>
<th>Ambulatory Level Two</th>
<th>Ambulatory Level Three</th>
<th>Corresponding LOCAT Feature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis stabilization and acute symptom reduction; serves as alternative to and prevention of hospitalization.</td>
<td>Stabilization, symptom reduction, and prevention of relapse.</td>
<td>Coordinated treatment for prevention of decline in functioning where outpatient services cannot adequately meet patient need.</td>
<td>The level one and level two requirements are consistent with Aetna’s network contracts (modeled on industry standards and based on APA definitions of levels of care). No deviation</td>
<td></td>
</tr>
<tr>
<td>Scheduled programming AABH: Minimum of four hours per day scheduled and intensive treatment over 4-7 days. LOCAT: Patients in mental health partial hospitalization (PHP) must 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</td>
<td>AABH: Minimum of 3-4 hours per day, at least 2-3 days per week. LOCAT: Patients in mental health intensive outpatient program (IOP) must 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</td>
<td>A minimum of four hours per week.</td>
<td>The level one and level two requirements are consistent with Aetna’s network contracts (modeled on industry standards and based on APA definitions of levels of care). No deviation</td>
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<tr>
<td></td>
<td>Ambulatory Level One</td>
<td>Ambulatory Level Two</td>
<td>Ambulatory Level Three</td>
<td>Corresponding LOCAT Feature</td>
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<tr>
<td>Crisis Backup Availability</td>
<td>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.</td>
<td>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.</td>
<td></td>
<td>The level one and level two requirements are consistent with Aetna’s network contracts (modeled on industry standards and based on APA definitions of levels of care). No deviation</td>
</tr>
<tr>
<td>Medical Involvement</td>
<td>An organized and integrated system of 24-hour crisis backup with immediate access to current clinical &amp; treatment information.</td>
<td>A 24-hour crisis and consultation service.</td>
<td>A 24-hour crisis and consultation service.</td>
<td>The level one and level two requirements are consistent with Aetna’s network contracts (modeled on industry standards and based on APA definitions of levels of care). No deviation</td>
</tr>
<tr>
<td>Medical Involvement</td>
<td>Medical supervision.</td>
<td>Medical consultation.</td>
<td>Medical consultation available.</td>
<td></td>
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<tr>
<td></td>
<td>Ambulatory Level One</td>
<td>Ambulatory Level Two</td>
<td>Ambulatory Level Three</td>
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<tr>
<td><strong>Accessibility</strong></td>
<td>Capable of admitting within 24 hours.</td>
<td>Capable of admitting within 48 hours.</td>
<td>Capable of admitting within 72 hours.</td>
<td>The level one and level two requirements are consistent with Aetna’s network contracts (modeled on industry standards and based on APA definitions of levels of care). No deviation</td>
</tr>
<tr>
<td><strong>Milieu</strong></td>
<td>Preplanned, consistent and therapeutic; primarily within treatment setting.</td>
<td>Active therapeutic within both treatment setting and home and community.</td>
<td>Active therapeutic; primarily within home &amp; community.</td>
<td>The level one and level two requirements are consistent with Aetna’s network contracts (modeled on industry standards and based on APA definitions of levels of care). No deviation</td>
</tr>
<tr>
<td><strong>Structure</strong></td>
<td>High degree of structure and scheduling.</td>
<td>Regularly scheduled, individualized.</td>
<td>Individualized and coordinated.</td>
<td>The level one and level two requirements are consistent with Aetna’s network contracts (modeled on industry standards and based on APA definitions of levels of care). No deviation</td>
</tr>
<tr>
<td><strong>Responsibility &amp; Control</strong></td>
<td>Staff aggressively monitors and supports patient and family.</td>
<td>Monitoring and support shared with patient family and support system.</td>
<td>Monitoring and support placed primarily with patient family and support system.</td>
<td>The level one and level two requirements are consistent with Aetna’s network contracts (modeled on industry standards and based on APA definitions of levels of care). No deviation</td>
</tr>
<tr>
<td>The Continuum of Ambulatory Behavioral Healthcare Services — Patient Variables</td>
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<td>---------------------------------------------------------------</td>
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<tr>
<td><strong>Level of Functioning</strong></td>
<td><strong>Ambulatory Level One</strong></td>
<td><strong>Ambulatory Level Two</strong></td>
<td><strong>Ambulatory Level Three</strong></td>
<td><strong>Corresponding LOCAT feature</strong></td>
</tr>
<tr>
<td>Severe impairment in multiple areas of daily life.</td>
<td>Marked impairment in at least one area of daily life.</td>
<td>Moderate impairment in at least one area of daily life.</td>
<td>The LOCAT contains six areas of concern or “dimensions” These five dimensions are: Dangerousness, <strong>Functional Impairment</strong>, Mental Status and Comorbid Factors, Psychosocial Factors, Additional Modifiers and Global Indicators. LOCAT is therefore more detailed, but entirely consistent with the AABH patient variables for level one and level two. No deviation.</td>
<td></td>
</tr>
<tr>
<td><strong>Psychiatric Signs &amp; Symptoms</strong></td>
<td>Severe to disabling symptoms related to acute condition or exacerbation of severe/persistent disorder.</td>
<td>Moderate to severe symptoms related to acute condition or exacerbation of severe/persistent disorder.</td>
<td>Moderate symptoms related to acute condition or exacerbation of severe/persistent disorder.</td>
<td>The LOCAT tool lists examples (including mental status and functioning) that represent anchor points along a continuum of symptoms with increasing degrees of clinical significance. The Aetna clinician uses these descriptions to aid in the decision-making process that determines the medically necessary level of care appropriate for effective treatment. LOCAT is therefore more detailed, but entirely consistent with the AABH patient variables for level one and level two. No deviation.</td>
</tr>
<tr>
<td><strong>Risk/Dangerousness</strong></td>
<td>Marked instability and/or dangerousness with high risk of confinement</td>
<td>Moderate instability and/or dangerousness with some risk of confinement.</td>
<td>Mild instability with limited dangerousness and low risk for confinement.</td>
<td>The LOCAT considers items related to dangerousness, including suicidal risk, self-injury (including poor compliance with treatment), risk of harming others, and irritability, aggression and mania. LOCAT is therefore very detailed, but entirely</td>
</tr>
<tr>
<td>Commitment to Treatment/ Follow-through</td>
<td>Ambulatory Level One</td>
<td>Ambulatory Level Two</td>
<td>Ambulatory Level Three</td>
<td>Corresponding LOCAT feature</td>
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<tr>
<td>Impaired ability to access or use caretaker, family or community support.</td>
<td>Inability to form more than initial treatment contract requires close monitoring and support.</td>
<td>Limited ability to form extended treatment contract requires frequent monitoring and support.</td>
<td>Ability to sustain treatment contract with intermittent monitoring and support.</td>
<td>The LOCAT contains dimensions that specifically consider factors related to treatment commitment and follow through, such as eating disorders (and need for supervision), psychotic symptoms, sabotage of treatment, poor compliance, substance abuse, medical illness, personality factors, insight, health literacy and past response to treatment. LOCAT is therefore more detailed, but entirely consistent with the AABH patient variables for level one and level two. No deviation.</td>
</tr>
<tr>
<td>Social Support System</td>
<td>Impaired ability to access or use caretaker, family or community support.</td>
<td>Limited ability to form relationships or seek support.</td>
<td>Ability to form and maintain relationships outside of treatment.</td>
<td>The LOCAT considers factors such as social isolation, family and non-family stress, housing, school or job, support system among other factors related to the psychosocial dimension. LOCAT is therefore entirely consistent with the AABH patient variables for level one and level two. No deviation.</td>
</tr>
</tbody>
</table>