LEVEL OF CARE GUIDELINES: ASSERTIVE COMMUNITY TREATMENT – OPTUM LOUISIANA

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INSTRUCTIONS FOR USE

This guideline is used to make coverage determinations as well as to inform discussions about evidence-based practices and discharge planning for behavioral health benefit plans managed by Optum®[1]. When deciding coverage, the member’s specific benefits must be referenced.

All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member’s benefits prior to using this guideline. Other clinical criteria may apply. Optum reserves the right, in its sole discretion, to modify its clinical criteria as necessary using the process described in Clinical Criteria.

This guideline is provided for informational purposes. It does not constitute medical advice.

Optum may also use tools developed by third parties that are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Optum may develop clinical criteria or adopt externally-developed clinical criteria that supersede this guideline when required to do so by contract or regulation.

ASSERTIVE COMMUNITY TREATMENT

ASSERTIVE COMMUNITY TREATMENT Adults

Assertive Community Treatment (a.k.a. Program of Assertive Community Treatment, PACT, ACT) is an intensive community-based program that uses a multi-disciplinary team of behavioral health professionals and trained peers to provide or coordinate treatment, rehabilitation, and community support services for members who are recovering from severe mental health conditions.

Assertive Community Treatment services are provided as interventions that address the functional problems of members who have the most complex and/or pervasive conditions associated with a major mental illness or co-occurring additions disorder. These interventions are strength-based and focused on promoting symptom stability, increasing the member’s ability to cope and relate to others and enhancing the highest level of functioning in the community.

[1] Optum is a brand used by United Behavioral Health and its affiliates.
Assertive Community Treatment services are therapeutic interventions that address the functional problems of individuals who have the most complex and/or pervasive conditions associated with a major mental illness or co-occurring addictions disorder. These interventions are strength-based and focused on promoting symptom stability, increasing the member’s ability to cope and relate to others and enhancing the highest level of functioning in the community.

Interventions may address adaptive and recovery skill areas, such as supportive or other types of housing, school and training opportunities, daily activities, health and safety, medication support, harm reduction, money management and entitlements and service planning and coordination.

Assertive Community Treatment services may be mobile or delivered within an outpatient treatment setting, and are available 24 hours a day, 7 days a week.

Assertive Community Treatment services vary in intensity, frequency, and duration in order to support the member’s ability to utilize behavioral health and medical services, manage functional difficulties, or otherwise realize recovery and resiliency goals.

1. Admission Criteria
   - see "Common Criteria and Best Practices for All Levels of Care":
   - The requested service is Medically Necessary in accordance with the Louisiana Administrative Code.¹
   - The member is diagnosed with one or more of the following Serious and Persistent Mental Illness (SPMI) diagnoses listed in the DSM 5 that seriously impairs their functioning in the community.
     - Schizophrenia
     - Other psychotic disorder
     - Bipolar disorder
     - Major depressive disorder
     - These may also be accompanied by any of the following:
       - Substance use disorder
       - Developmental disability
   - The member meets 2 or more of the following:
     - Two or more acute psychiatric hospitalization and/or four or more emergency room visits in the last six months.
     - Persistent and severe symptoms of a psychiatric disability that interferes with the ability to function in daily life.
     - Two or more interactions with law enforcement in the past year for emergency services due to mental illness or substance use (this includes involuntary commitment, ACT/Forensic Assertive Community Treatment (FACT)).
     - Currently residing in an inpatient bed, but clinically assessed to be able to live in a more independent situation if intensive services were provided.
     - One or more incarcerations in the past year related to mental illness and/or substance use (FACT).

¹ According to LAC 50:I.1101:
A. Medically necessary services are defined as those health care services that are in accordance with generally accepted evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care.
B. In order to be considered medically necessary, services must be:
   (1) Deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction.
   (2) Those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the recipient.
C. Any such services must be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time.
D. Although a service may be deemed medically necessary, it doesn’t mean the service will be covered under the Medicaid program. Services that are experimental, non-FDA approved, investigational or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary".
1. The Medicaid director, in consultation with the Medicaid medical director, may consider authorizing services at his discretion on a case-by-case basis.
- Psychiatric and judicial determination that FACT services are necessary to facilitate release from a forensic hospitalization or pre-trial to a lesser restrictive setting (FACT).
- Recommendations by probation and parole, or a judge with a FACT screening interview, indicating services are necessary to prevent probation/parole violation (FACT).

AND

- The member meets 1 of the following:
  - Inability to participate or remain engaged or respond to traditional community-based services.
  - Inability to meet basic survival needs, or residing in substandard housing, homeless or at imminent risk of becoming homeless.
  - Services are necessary for diversion from forensic hospitalization, pretrial release or as a condition of probation to a lesser restrictive setting (FACT).

AND

- The member meets 3 of the following:
  - Evidence of co-existing mental illness and substance use disorder.
  - Significant suicidal ideation, with a plan and ability to carry out within the last 2 years.
  - Suicide attempt in the last 2 years.
  - History of violence due to untreated mental illness/substance use within the last 2 years.
  - Lack of support systems.
  - History of inadequate follow-through with treatment plan, resulting in psychiatric or medical instability.
  - Threats of harm to others in the past 2 years.
  - History of significant psychotic symptomatology, such as command hallucinations to harm others.
  - Minimum LOCUS score of 3.
    - Exception: The member does not meet medical necessity criteria I or II, but is recommended as appropriate to receive ACT services by the funding agency or designee, the ACT team leader, clinical director and psychiatrist, in order to protect public safety and promote recovery from acute symptoms related to mental illness.

2. Continued Service Criteria

- see "Common Criteria and Best Practices for All Levels of Care":
- Service provision is based on a comprehensive history and assessment must be completed within 30 days of admission. These will include:
  - Psychiatric history, status and diagnosis.
  - Level of Care Utilization System (LOCUS).
  - Telesage Outcomes Measurement System, as appropriate.
  - Psychiatric evaluation.
  - Housing and living situation.
  - Vocational, educational and social interests and capacities.
  - Self-care abilities.
  - Family and social relationships.
  - Family education and support needs.
  - Physical health.
  - Alcohol and drug use.
  - Personal and environmental resources.
  - Linkages with the forensic system for members involved in the judicial system, including items related to court orders, updated every 90 days or as new court orders are received.

- A service plan, responsive to the member’s preferences and choices must be developed and in place at the time services are rendered. The service plan will include input of all staff involved in treatment of the member, as well as involvement of the member and collateral others of the member’s choosing. The plan must contain the signature of the psychiatrist, the team leader involved in the treatment and the member (or documented refusal). The plan must consist of the following:
  - The member’s specific mental illness diagnosis.
  - Plans to address all psychiatric conditions.
  - The member’s treatment goals and objectives (including target dates), preferred treatment approaches and related services.
  - The member’s educational, vocational, social, wellness management, and residential or recreational goals, associated concrete and measurable objectives and related services.
  - The member’s goals and plans, and concrete and measurable objectives necessary for a person to get and keep their housing.
- When psycho-pharmacological treatment is used, a specific service plan, including identification of target symptoms, medication, doses and strategies to monitor and promote commitment to medication must be used.
- A crisis/relapse prevention plan, including and advance directive.
- An integrated substance use and mental health service plan for individuals with co-occurring disorder (COD).
- Any other items that are relevant for any specialized interventions, including linkages with the forensic system for consumers involved in the judicial system.

- ACT staff must be providing a minimum of 6 encounters with the member or collateral contacts monthly and must document clinically appropriate reasons if this minimum number of encounters cannot be made monthly. At least 50% of the encounters shall be with the member. Efforts shall be made to ensure services are provided throughout the month.
- At least 60% of all ACT team activities must be face-to-face, with approximately 90% to these encounters occurring outside of the office. The LOCUS, psychiatric evaluation and treatment plan must be updated every 6 months.

3. Discharge Criteria
- see "Common Criteria and Best Practices for All Levels of Care":
- An additional LOCUS score must be completed prior to discharge.

4. Clinical Best Practices
- see "Common Criteria and Best Practices for All Levels of Care":

5. Exclusions
- ACT services are comprehensive of all other services, with the exception of psychological evaluation or assessment and medication management.
- ACT shall not be billed in conjunction with the following services:
  - Behavioral health services by licensed and unlicensed individuals, other than medication management and assessment.
  - Residential services, including professional resource family care.

REFERENCES*


Additional reference materials can be found in the reference section(s) of the applicable Level of Care Guidelines and in the related Behavioral Clinical Policy

HISTORY/REVISION INFORMATION

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