Clinical UM Guideline

Subject: Assertive Community Treatment
Guideline #: CG-BEH-09 **Publish Date:** 04/25/2018
Status: Reviewed **Last Review Date:** 03/22/2018

Description

This document addresses Assertive Community Treatment (ACT), also identified as Program of Assertive Community Treatment (PACT) or Intensive Community Treatment (ICT). The medical necessity criteria outlined in this document for ACT/PACT, or equivalent program such as ICT, includes two categories; Severity of Illness and Continued Stay. Severity of Illness criteria includes descriptions of the member's condition and circumstances. For continued authorization of the requested service, Continued Stay criteria must be met along with Severity of Illness criteria.

ACT is a specialized model of treatment and service delivery designed to provide comprehensive community-based mental health services to persons with serious and persistent mental illness (SPMI) who have severe functional impairments and who have not responded to traditional psychiatric outpatient treatment or less intensive non-standard levels of outpatient mental health treatment. Services are available to individuals with SPMI who have had a history of multiple psychiatric hospitalizations and/or crisis interventions. ACT/PACT services are provided over an extended period of time and include clinical, rehabilitation, recovery, supportive and case management services provided directly by a multidisciplinary team in the individual's natural environment. ACT/PACT serves as the primary provider of services, available 24 hours a day, 7 days a week.

Please see the following related document for additional information:

- CG-BEH-03 Psychiatric Disorder Treatment

Clinical Indications

Medically Necessary:

Severity of Illness (SI)

ACT/PACT is considered **medically necessary** when member has **ALL** of the following:

A. Serious and persistent (typically six months) symptoms or disturbances of mood and/or behavior are present, with severe functional impairment caused by a mental condition (DSM-5/ICD) that impedes the member's ability to live successfully in the community, and these disturbances/symptoms are likely to improve with treatment; **and**
B. Interventions focus on the present symptoms and complaints that have led to a decrease in the member's cognitive and behavioral functioning; **and**
C. The member meets one or more of the following:
    1. Has been discharged from an inpatient, residential or partial hospitalization program (PHP) service and more frequent outpatient (OP) treatment is required as a transition for the purposes of stabilization while returning to the community; **or**
    2. Has had repeated and/or lengthy admissions to inpatient psychiatric facilities with minimal community tenure; **or**

3. Substantial decline as evidenced by significant impairments in function that is manageable on an outpatient basis. Substantial decline is defined, but is not limited to, an unexpected increase in symptoms and/or behaviors or worsening in mood; **and**

D. A well-defined clinical rationale is documented that explains why the member has not or would not be a candidate for traditional outpatient therapy combined with community support where the treatment goals are focused on stabilization to manage decline; **and**

E. The member demonstrates motivation for treatment and is capable of benefiting from the treatment approach planned.

Continued Stay Criteria (CS)

ACT/PACT is considered **medically necessary** when member has **ALL** of the following:

A. Member continues to meet Severity of Illness criteria; **and**

B. Documentation of members participation and engagement in services; **and**

C. Symptoms and/or functional impairment of at least moderate degrees as evidenced by report of specific domains are still present related to the DSM-5/ICD diagnosis listed and likely to improve with continued treatment; **and**

D. The goals of treatment are not primarily for providing support, targets are not primarily symptoms/behaviors which are either chronic and not likely to improve with ACT/PACT, or primarily self-improvement; **and**

E. Coordination of care with other clinicians providing care to the member and evidence of this is documented; **and**

F. ACT/PACT is involving family members where indicated; **and**

G. The member meets **one** of the following:

1. Progress with the targeted symptoms/behaviors and/or mood is documented at the expected pace given the presence of medical/physical conditions, stressors and level of support, as evidenced by adherence with treatment, improving severity of symptoms and functional impairment, and continued progress is expected for the targeted symptoms and behaviors or mood with the treatment approaches being used; **or**
2. If progress is not documented, either diagnosis has been re-evaluated and changed if appropriate, medication has been re-evaluated and changed if indicated, or the treatment approach has been re-evaluated and changed if appropriate to include new treatment goals/targets.

Not Medically Necessary:

ACT/PACT is considered **not medically necessary** when the above criteria are not met.

Coding

The following codes for treatments and procedures applicable to this guideline are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

HCPCS

H0039	Assertive community treatment, face-to-face, per 15 minutes
H0040	Assertive community treatment program, per diem

ICD-10 Diagnosis

	For the following diagnoses, including but not limited to:
F01.50-F99	Mental, behavioral, and neurodevelopmental disorders

Discussion/General Information

ACT/PACT programs provide a greater intensity of service in the community than is characteristic of many other types of outpatient behavioral health treatment. The population served by ACT is burdened with severe and persistent mental illness or are children and adolescents with serious emotional disorders. Services provided to children and adolescents are especially likely to include family and/or other concerned and responsible adults. Medical literature indicates that ACT programs have a significant impact for many program participants. Research on ACT suggests that including ACT and related types of service in an integrated treatment program that is sensitive to member needs makes ACT more effective (SAMHSA, 2008; Schöttle, 2014).

Standard components of ACT/PACT include:

- Assertive outreach
- Person-centered treatment planning
- Mental health treatment, including individual therapy
- Social skills training
- Medication monitoring and support
- Integrated dual disorder treatment
- Group therapy
- Family education
- Vocational services
- Daily living and other skill development
- Wellness skills
- Crisis planning and response
- Monitoring for health care needs
- Coordination of care and services (e.g. medical, behavioral, long-term care)
- Peer support
- Community integration as clinically and functionally appropriate

Standard outcomes of ACT/PACT include:

- Improved mental functions (orientation and emotional functions)
- Improved learning and application of knowledge
- Improved communication
- Improved mobility
- Improved self-care
- Improved domestic life
- Improved interpersonal interactions and relationships
- Improved communication and social life
- Improved support and relationships

In an ACT/PACT program, multidisciplinary treatment should be provided based on member's frequency and intensity needs with at least 1 visit per week. A comprehensive assessment is completed face to face prior to the provision of ACT services with a person-centered treatment plan created to address psychological, social, medical, cognitive, and basic needs. Treatment goals should target resolution of specific symptoms or stabilization of mood and/or behavior consistent with the DSM-5/ICD diagnoses listed. Treatment goals should also focus on the improvement in skills to self-manage their psychiatric illness, and target specific domains of

functional impairment. Weekly team meetings should occur to promote shared responsibility and assertive engagement. Discharge plans should be individualized and include a projected discharge date. Service performed must teach the member about medication management and adherence when medications are prescribed, and if not, there is documentation of the reason and education addressing the lack of medication provided. Care addressing substance use/dependence should be provided when a diagnosis of substance use disorder is present or there is a risk for the development of a substance use disorder. ACT/PACT promotes communication between all involved providers. The ACT/PACT program is coordinated with the primary care provider and is documented. Coordination of care with other clinicians providing services to the member including psychiatrist/therapist should be documented. Community/natural supports and resources should be identified and utilized. Skills training should include the development of and communication with community/natural supports, including school/work, self-help or diagnosis specific support groups, spiritual/religious, and community recreational activities. Family and other responsible individuals involved in the members care should be informed and included as circumstances allow. Family participation in treatment should be documented unless contraindicated with rationale noted. Services are typically provided in places such as the individual's home, community organizations, and neighborhood. Treatment should not duplicate other services being provided for the same reasons/diagnoses. ACT/PACT should not be used primarily for the avoidance of incarceration of the member or to satisfy a programmatic length of stay (refers to a predetermine number of days or visits for a program's length instead of an individualized determination of how long a member needs to be in that program). There should be a reasonable expectation that the member's illness, condition, or level of functioning will be stabilized, improved, or maintained through treatment known to be effective for the member's illness. The Dartmouth Assertive Community Treatment Scale (DACTS) was developed to assess ACT program fidelity. The assessment is reasonable for each ACT program evaluation of program performance.

Definitions

Assertive community treatment: A service delivery model that provides case-management based treatment, rehabilitation, and support services. The intervention is a person-centered, recovery-based approach for individuals diagnosed with a severe and persistent mental illness. Services are provided to individuals by a mobile, multi-disciplinary team in community settings. The goal of ACT is to assist individuals to achieve their personally meaningful goals and life roles.

Outpatient treatment: A mental health professional licensed to practice independently provide care to members in an outpatient setting, usually an office. Services may be provided individually, as family therapy, or to a group of people. A wide range of behavioral health disorders of varying severity and chronicity can respond to outpatient treatment.

Severe Mental Illness (also known as serious and persistent mental illness): A mental, behavioral or emotional disorder according to the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, in members 18 years and older, that results in functional impairment which substantially interferes with or limits one or more major life activities (e.g., maintaining interpersonal relationships, activities of daily living, self-care, employment, recreation) that have occurred within the last year. All of these disorders may have acute episodes as part of the chronic course of the disorder. An organization may also use its state's definition or the definition of another appropriate regulatory authority (SAMHSA, 2016).

References

Peer Reviewed Publications:

1. Chien WT, Leung SF, Yeung FK, Wong WK. Current approaches to treatments for schizophrenia spectrum disorders, part II: psychosocial interventions and patient-focused perspectives in psychiatric care. Neuropsychiatr Dis Treat. 2013; 9:1463-1481.
2. de Vet R, van Luijtelaar MJ, Brilleslijper-Kater SN, et al. Effectiveness of case management for homeless persons: a systematic review. Am J Public Health. 2013; 103(10):e13-e26.
3. Killaspy H, Mas-Exposito L, Marston L, King M. Ten year outcomes of participants in the REACT (Randomised Evaluation of Assertive Community Treatment in North London) study. BMC Psychiatry. 2014; 14:296-306.
4. Kubitz N, Mehra M, Potluri RC, et al. Characterization of treatment resistant depression episodes in a cohort of patients from a US commercial claims database. PLoS. 2013; 8(10):e76882.
5. Liem SK, Lee CC. Effectiveness of assertive community treatment in Hong Kong among patients with frequent hospital admissions. Psychiat Serv. 2013; 64(11):1170-1172.
6. McGrew JH, Pescosolido B, Wright E. Case managers' perspectives on critical ingredients of assertive community treatment and on its implications. Psychiat Serv. 2003; 54(3):370-376.
7. Mueser KT, Deavers F, Penn DL, Cassisi JE. Psychosocial treatments for schizophrenia. Annu Rev Clin Psychol. 2013; 9:465-497.
8. Philips SD, Burns BJ, Edgar ER, et al. Moving assertive community treatment into standard practice. Psychiatr Serv. 2001; 52(6):771-779.
9. Schöttle D, Schimmelmann BG, Karow A, et al. Effectiveness of integrated care including therapeutic assertive community treatment in severe schizophrenia spectrum and bipolar I disorders: the 24-month follow-up ACCESS II study. J Clin Psychiatry. 2014; 75(12):1371-1379.
10. Teague GB, Bond GR, Drake RE. Program fidelity in assertive community treatment: development and use of a measurement. Am J Orthopsychiatry. 1998; 68(2):216-232.
11. Ziguras SJ, Stuart GW. A meta-analysis of the effectiveness of mental health case management over 20 years. Psychiatr Serv. 2000; 51(11):1410-1421.

Government Agency, Medical Society, and Other Authoritative Publications:

1. National Alliance on Mental Illness. Psychosocial treatments. Assertive Community Treatment (ACT) Assertive Community Treatment (ACT). Available at: https://www.nami.org/Learn-More/Treatment/Psychosocial-Treatments. Accessed on January 27, 2018.
2. Substance Abuse and Mental Health Service Administration. Assertive Community Treatment: evidence based practice kit. 2008 Available at: http://store.samhsa.gov/shin/content//SMA08-4345/TheEvidence.pdf. Accessed on January 27, 2018.
3. Substance Abuse and Mental Health Services Administration (SAMHSA). National Registry of Evidence-based Programs and Practices. Behind the term: serious mental illness. 2016. Available at: http://www.nrepp.samhsa.gov/Docs/Literatures/Behind_the_Term_Serious%20%20Mental%20Illness.pdf. Accessed on January 27, 2018.
4. World Health Organization. International Classification of Functioning, Disability, and Health (ICF). May 2001. Available at: http://www.who.int/classifications/icf/en/. Accessed on January 27, 2018.

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History

Status	Date	Action
Reviewed	03/22/2018	Medical Policy & Technology Assessment Committee (MPTAC) review.

Reviewed	02/23/2018	Behavioral Health Subcommittee review. The document header wording updated from "Current Effective Date" to "Publish Date." Updated References section.
Reviewed	08/03/2017	MPTAC review.
Reviewed	07/21/2017	Behavioral Health Subcommittee review. Minor format changes to Clinical Indications section. Updated Discussion/General Information and References sections. Removed Websites for Additional Information section.
Reviewed	08/04/2016	MPTAC review.
Reviewed	07/29/2016	Behavioral Health Subcommittee review. Updated formatted in clinical indication section. Revised title to: Assertive Community Treatment. Updated Discussion, References and Websites section. Removed ICD-9 codes from Coding section.
Revised	08/06/2015	MPTAC review.
Revised	07/31/2015	Behavioral Health Subcommittee review. Reformatted and clarified medically necessary SI and CS criteria. Removed IS criteria from medically necessary position statement and moved to the Discussion section. Description, Discussion, and References sections updated.
Reviewed	02/05/2015	MPTAC review.
Reviewed	01/30/2015	Behavioral Health Subcommittee review. Updated References.
New	08/14/2014	MPTAC review.
New	08/08/2014	Behavioral Health Subcommittee review. Initial document development

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Federal and State law, as well as contract language, and Medical Policy take precedence over Clinical UM Guidelines. We reserve the right to review and update Clinical UM Guidelines periodically. Clinical guidelines approved by the Medical Policy & Technology Assessment Committee are available for general adoption by plans or lines of business for consistent review of the medical necessity of services related to the clinical guideline when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether to adopt a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the member's card.

Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan's or line of business's members may instead use the clinical guideline for provider education and/or to review the medical necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.