

Clinical Policy: Assertive Community Treatment

Reference Number: TX.CP.MP.548

Last Review Date: 10/19

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Description

To ensure that individuals in Assertive Community Treatment (ACT) are provided pharmacological management in the form of medications, medication training and supports, i.e. patient and family education; psychosocial rehabilitation; rehabilitative case management including housing services; co-occurring substance use services; skills training and development; supported employment; and medical services by a registered nurse (RN). Services provided by an ACT team are focused on outreach, engagement, and stabilization; are all-inclusive and made available 24 hours a day, seven days per week.

This policy is for contracted providers requesting H0039 services and serves to establish criteria for medical necessity. This policy applies to following products: STAR, STAR+PLUS, STAR Health, STAR Kids, MMP, and CHIP.

Policy/Criteria

- I. It is the policy of Superior HealthPlan that assertive community treatment is **medically necessary** when all of the following are met:
 - A. The member has a severe and persistent mental illness that seriously impairs the ability to live in the community. Potential diagnoses include schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), bipolar disorder, or major depressive disorder with psychotic features;
 - B. The member has significant functional impairments, as demonstrated by the inability to consistently engage in at least one of the following:
 1. Maintaining personal hygiene;
 2. Meeting nutritional needs;
 3. Obtaining medical, legal, and housing services;
 4. Recognizing and avoiding common dangers or hazards to self and possessions;
 5. Persistent or recurrent failure to perform daily living tasks, except with significant support or assistance from others, such as friends, or relatives;
 6. Maintaining employment at a self-sustaining level or carrying out homemaker roles (e.g. household meal preparation, washing clothes, budgeting, or childcare tasks and responsibilities);
 7. Maintaining a safe living situation (e.g., repeated evictions or loss of housing);
 - C. The member has one or more of the following problems that are indicators of continuous, high-service needs:
 1. High use of acute psychiatric hospitals or crisis/emergency services, including mobile, in-clinic or crisis residential care (e.g. two or more admission in the past 180 days or four or more in the past two years);
 2. Persistent, recurrent, severe, or major symptoms (e.g. affective, psychotic, suicidal);

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3. Coexisting substance use disorder of significant duration (e.g. greater than six months) or co-diagnosis of substance abuse;
 4. High risk for or with a recent history of criminal justice involvement (e.g. arrest and incarceration);
 5. Inability to meet basic survival needs or residing in substandard housing, or is homeless, or at imminent risk of becoming homeless;
 6. Inability to participate in traditional clinic-based services;
 7. Lower level of service/support has been tried or considered and found to be inappropriate.
- D. Request is for one of the following:
1. Initial approval;
 2. Continued stay, and the provider has documented that the member is receiving the scope and intensity of services required to meet the following program goals, as applicable:
 - a. Pharmacological management in the form of medications, medication training and supports;
 - b. Patient and family education;
 - c. Psychosocial rehabilitation;
 - d. Rehabilitative case management including housing services;
 - e. Co-occurring substance use services;
 - f. Skills training and development;
 - g. Supported employment;
 - h. Medical services by a registered nurse.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
H0039	Assertive community treatment, face-to-face, per 15 minutes

HCPCS Codes	Description
N/A	



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ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
N/A	

Reviews, Revisions, and Approvals	Date	Approval Date
New Policy	09/18	09/18
Updated to new template from TX.UM.48 (TX.CP.MP.548 nomenclature implementation 10/1/19). Restructured criteria. Added reference information.	10/19	10/19

References

1. Larry Mack, Crystal Counseling Growth and Clarity Contract, San Antonio, TX, Medical Necessity Criteria, 2014.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan



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retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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