Medical Necessity Guidelines:
Program of Assertive Community Treatment (PACT) Services

Effective: January 1, 2020

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request.	**Yes ☐ No ☒**

Applies to:

COMMERCIAL Products

☐Tufts Health Plan Commercial products; Fax: 617.972.9409

☐Tufts Health Freedom Plan products; Fax: 617.972.9409

- CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

TUFTS HEALTH PUBLIC PLANS Products

☐Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax:888.415.9055

☒Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055

☐ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404

☒Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 857.304.6304

*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

SENIOR Products

- Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) – Refer to the Tufts Health Plan SCO Prior Authorization List
- Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

OVERVIEW

The **Program of Assertive Community Treatment (PACT)** is a multidisciplinary service team approach to providing intensive, community-based, and recovery-oriented psychiatric treatment, assertive outreach, rehabilitation, and support to individuals with serious mental illness. The service is best suited to Members who do not effectively use less-intensive psychiatric services. The program team provides assistance to individuals to maximize their recovery, ensures consumer-directed goal setting, assists individuals in gaining hope and a sense of empowerment, and provides assistance in helping individuals become better integrated into their community. The team is the single point of clinical responsibility and assumes accountability for assisting individuals in getting their needs met while achieving their goals for recovery. The PACT team provides all clinical non-acute behavioral health and substance use disorder interventions in addition to linking Members to community-based self-help resources and providing direct rehabilitation, vocational, and housing-related services. Services are delivered in the individual's natural environment and are available on a 24-hour, seven-day-a-week basis. Services are comprehensive and highly individualized. They are modified as needed through an ongoing assessment and treatment planning process. Services are intensive but may vary based on the needs of the individuals served.

PACT services follow national program guidelines from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

CLINICAL COVERAGE CRITERIA

Tufts Health Plan may cover PACT services if **all** of the following criteria (1-5) are met:

1. The individual must be an adult, age 19 or older, and/or a DMH client on the date of service;
2. The individual must have a psychiatric diagnosis as defined in the DSM-5;
3. As a result of the psychiatric diagnosis, the individual has significant functional impairments as demonstrated by at least one of the following conditions:

   a. Inability to consistently perform practical daily living tasks (e.g., maintaining personal hygiene; meeting nutritional needs; caring for personal financial affairs; obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions; budgeting; employment or carrying out child-care responsibilities) or persistent or recurrent failure to perform daily living tasks except with significant support or assistance from others (such as friends, family, or relatives);
   b. Inability to maintain a safe living situation (e.g., repeated evictions or loss of housing); or
   c. High risk or recent history of criminal justice involvement (e.g., arrest and incarceration).
4. One or more of the following indicators of continuous, high-service need is present:
   a. Non-responsive to Tufts Health Plan's Care Management services (not applicable for DMH clients);
   b. The Member has a history of psychiatric hospital admissions or psychiatric Emergency Services visits in the last 365 days;
   c. Active, co-existing substance use disorder greater than six months' duration;
   d. Currently admitted to an acute level of care or supervised community residence but able to be discharged if intensive community support services are provided;
   e. In danger of requiring acute level of care if more intensive services are not available; or
   f. Inability to keep office-based appointments.
5. The individual and legal guardian, if appropriate, are willing to accept and cooperate with the PACT team.

Tufts Health Plan may continue coverage for PACT services when **all** of the following criteria (1-5) are met:

1. Severity of illness and resulting impairment continue to require this level of service;
2. Treatment planning is individualized and appropriate to the individual's changing condition, with realistic and specific goals and objectives stated;
3. The mode, intensity, and frequency of treatment are appropriate;
4. Active treatment is occurring, and continued progress toward goals is evident; or adjustments to the treatment plan have been made to address lack of progress; and
5. The individual and family (when appropriate and with consent) are participating to the extent capable with a program that is considered adequate to alleviate the signs and symptoms justifying treatment.

A member may be discharged from PACT services when **any one** of the following criteria (1-5) are met:

1. The individual's treatment plan and discharge goals have been substantially met;
2. Consent for treatment is withdrawn;
3. The individual no longer meets the admission criteria or meets criteria for a less- or more-intensive level of care;
4. The Member is in an institution (state hospital or prison) for an extended period of time which precludes the PACT team's ability to maintain a relationship with the Member, or there is no planned return to the community set to occur within a reasonable time frame; or
5. The Member and/or legal guardian is not engaged in or utilizing the service to such a degree that treatment at this level of care becomes ineffective or unsafe despite use of motivational techniques and multiple, documented attempts to address engagement issues. In addition, it has been determined that the Member and/or guardian has the capacity to make an informed decision, and the Member does not meet criteria for a more-intensive level of care.

**Please note that Psychosocial, Occupational, and Cultural and Linguistic Factors, as detailed in the overview, may change the risk assessment and should be considered when making level-of-care decisions.*

LIMITATIONS

Tufts Health Plan will not cover PACT services if **any one** of the following criteria (1-5) is met:

1. The individual has a diagnosis of a substance use disorder only;
2. The individual has a primary diagnosis of intellectual disability;
3. The individual has a primary diagnosis of a neurodevelopmental or neurocognitive disorder;
4. The individual is actively engaged in treatment in a Community Support Program (CSP) or similar duplicative service; or
5. The individual has an impairment that requires a more-intensive level of service than community-based intervention.

CODES

The following CPT/HCPCS code(s) are associated with PACT services:

Table 1: CPT Codes

CPT/HCPCS Code	Description
H0040	Assertive community treatment program, per diem

1. Substance Abuse and Mental Health Services Administration. Assertive Community Treatment (ACT) Evidence-Based Practices (EBP) Kit. DHHS Pub. No. SMA-08-4345, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2008.
2. Massachusetts Behavioral Health Partnership (MBHP) Medical Necessity Criteria for Program of Assertive Community Treatment (PACT), Accessed at masspartnership.com/pdf/MNC-PACT.pdf, on August 12, 2020.

APPROVAL HISTORY

January 20, 2021 : Reviewed and approved by the Integrated Medical Policy Advisory Committee. Effective date is January 1, 2020.

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Medical Necessity Guidelines are developed to determine coverage for benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.