# Clinical Policy: Assertive Community Treatment (ACT)

Reference Number: SC.CP.BH.500
Date of Last Revision: 02/2024

Coding Implications
Revision Log

**See Important Reminder at the end of this policy for important regulatory and legal information.**

**Description**

This policy applies to all staff members involved in the design, implementation, operation, and management of Behavioral Health utilization management services for Absolute Total Care. It outlines the utilization management process for authorization requests for Assertive Community Treatment (ACT) services, in accordance with guidelines set forth by the South Carolina Department of Health and Human Services (SCDHHS), The Centers for Medicare and Medicaid (CMS), the Code of Federal Laws and Regulations (CFR), and the South Carolina Code of Laws and Regulations. The ACT team is responsible for ensuring that staff composition and qualifications meet state and/or federal requirements, including certification as an ACT team in fidelity with the TMACT. By requesting authorization for ACT services, the ACT team, or their designee, acknowledges that all regulatory requirements have been met and that they are qualified to provide the requested services in accordance with all other state and/or federal practice guidelines. Furthermore, by submitting claims for services that are eligible for reimbursement under state and federal Medicaid rules, providers certify that the billed services were medically necessary according to the clinical criteria set forth in this policy, as well as all other plan and regulatory guidelines. The provider or their designee also affirms that they are authorized by Medicaid to provide ACT services, and that the services rendered for which reimbursement is being sought are within their professional scope.

Assertive Community Treatment (ACT) is a best practice, community-based treatment for members with severe mental illness (SMI). ACT services are designed to assist members in decreasing psychiatric hospitalizations and involvement with law enforcement, while increasing their community living skills. The Substance Abuse and Mental Health Services Administration (SAMHSA) recognizes ACT as an evidence-based best practice for adults and transition-age youth (i.e., 18-26 years) that is cost-effective and highly satisfactory for both individuals receiving the service and their family members.

One of the fundamental principles of ACT is to serve as the primary (and often sole) provider of all behavioral health services that members may require. As such, a high frequency and intensity of community-based contacts, as well as a low member-to-staff ratio, are necessary. Services are flexible and adjusted based on the member's evolving needs over time. The ACT team is expected to thoughtfully employ assertive engagement techniques, including rapport-building strategies, facilitating the meeting of basic needs, and motivational interviewing techniques, to identify and focus on the member's life goals and motivations for change. It is also the team's responsibility to monitor the member's mental status and provide necessary support in a manner consistent with their level of need and functioning. All services provided by the ACT team are delivered according to a recovery-based philosophy of care, promoting self-determination, respecting the individuality of the member, and engaging peers in promoting hope for recovery from mental illness and the regaining of meaningful roles and relationships in the community.

**Policy/Criteria**

**I.** It is the policy of Absolute Total Care and Centene Advanced Behavioral Health that a medical director will review **initial requests** for Assertive Community Treatment (ACT) services, on a case-by-case basis, and is considered **medically necessary** when meeting **all** (**A-F**) of the following **Entrance Criteria**:

**A.** Age 18 years of age or older.

**B.** The service authorization request includes clinical documentation confirming the member's diagnosis and condition meets **both** (**1 and 2**) of the following requirements:

**1.** The member has a confirmed primary diagnosis of anyone (**a-d**) of the following mental health disorders as listed in the most current version of the Diagnostic and Statistical Manual (DSM):

**a)** Schizophrenia spectrum, or;

**b)** Bipolar disorder, or;

**c)** Other Psychotic disorders (e.g. schizoaffective disorders), or;

**d)** Other psychiatric illnesses may be eligible, depending on the level of long-term disability from the mental illness (unless otherwise noted below in **C**).

**2.** The diagnosis reflects a serious and persistent mental illness and need for treatment. ACT can be reasonably expected to meet the member's specific preventive, diagnostic, therapeutic, or rehabilitative needs in the management and/or treatment of the qualifying diagnosis.

**C.** The member does **not** have a primary diagnosis of **any** (**1-4**) of the following:

**1.** Substance use disorder.

**2.** Intellectual Developmental Disorder (intellectual disability).

**3.** Borderline personality disorder.

**4.** Traumatic Brain Injury.

**D.** Request is for **one (1)** ≤ to **six (6)** months of ACT and for **nine (9)** ≤ to **fifteen (15)** days per month. *Note: See prior authorization, continuity of care, and reimbursement information below.*

**E.** The member has significant functional impairment as demonstrated by at least **one (1-3)** of the following conditions that is clearly documented:

**1.** Significant difficulty consistently performing the range of routine tasks required for basic adult functioning in the community (e.g. caring for personal business affairs, obtaining medical, legal, and housing services, recognizing and avoiding common dangers or hazards to self and possessions, meeting nutritional needs, attending to personal hygiene, or, persistent or recurrent difficulty performing daily living tasks without significant support or assistance from others such as friends, family, or relatives.

**2.** Significant difficulty maintaining consistent employment at a self-sustaining level or significant difficulty consistently carrying out the head-of-household responsibilities (e.g. meal preparation, household tasks, budgeting, or childcare tasks and responsibilities.

**3.** Significant difficulty maintaining a safe living situation (e.g. repeated evictions or loss of housing or utilities)

**F.** The member has indicators of continuous high service needs demonstrated by at least **one (1-7)** of the following problems:

**1.** High use of acute psychiatric hospitalization (two or more admissions during the past 12 months) or psychiatric emergency services

**2.** Intractable (persistent or recurrent) severe psychiatric symptoms (e.g. affective, psychotic, suicidal, etc.).

3. Coexisting mental health and substance use disorders of significant duration (more than six months)
4. High risk of recent history of criminal justice involvement (e.g. detention, incarceration, probation, frequent contacts with law enforcement, etc.).
5. Significant difficulty meeting basic survival needs, residing in substandard housing, homelessness, or imminent risk of homelessness.
6. Residing in an inpatient or supervised community residence but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or requiring residential or institutional placement if more intensive services are not available.
7. Difficulty effectively using traditional office-based outpatient services.

**II.** For **newly enrolled members**, requests for Assertive Community Treatment (ACT) services will be considered **medically necessary** for **continuity of care (CoC)** and processed as a request for **continued stay** after initial authorization of ACT services under the following conditions (**Both A and B**):

**A.** The member is newly enrolled with Absolute Total Care (newly enrolled is defined as being enrolled for less than 90 consecutive days) **and** ACT services were previously approved by another MCO or SCDHHS, automatic approval may be granted and duration of authorization is the longer of any **one** (**1-3**) of the following:
1. Through the 90th day if enrolled 0-59 days ago, or;
2. 30 days (minimum) if enrolled 60 - 90 days ago), or;
3. Original **end date** of approved authorization from previous MCO or SCDHHS. *Note: A copy of the approval notice showing approval duration dates must be submitted to Absolute Total Care (approval duration not to exceed 6 months= combined Absolute Total Care and prior SCDHHS/MCO authorization).*

**B.** The frequency approved under the continuity of care guideline must still be at least **nine (9) days** but not to exceed **fifteen (15) days** per month. *Note: Please see prior authorization, continuity of care, and reimbursement below for important information, limitations, and guidelines.*

**III.** **Subsequent requests** for Assertive Community Treatment (ACT) services will be reviewed on a case-by-case basis, and is considered **medically necessary** when meeting **all** (**A-D**) of the **continued stay** criteria as follows:

**A.** Request is for **one (1)** ≤ to **six (6)** months of ACT and for **nine (9)** ≤ to **fifteen (15)** days per month. *Note: See prior authorization, continuity of care, and reimbursement information below.*

**B.** The previous utilization over the course of the previous authorization period was **nine (9)** days/month or greater. If billing and utilization is below the minimum range average from the previous authorization period, then **one** (**1 or 2**) of the following must apply to continue ACT services:
1. Utilization averaging less than **nine (9)** days/month but **six (6)** or more days/month will be reviewed on a case-by-case basis by our medical director to evaluate whether this level of care (LOC) is appropriate, and a determination will be made for **one** (**a-c**) of the following:
   **a)** Continue ACT services as requested.
   **b)** Continue ACT services for a shorter duration (1 to 5 months) then re-evaluate utilization.
   **c)** Considered **not medically necessary** and member should transition to a lower LOC.

**2.** Utilization averaging five (5) days/month or less over a three-to-four-month period, continuing stay criteria is not met or authorized, and this LOC is not medically necessary.

**C.** The member meets all the initial criteria from section **I** or **II** above as evidenced by authorization previously approved by Absolute Total Care and less than a 90-day lapse since authorization ended.

**D.** The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the member's treatment plan, or the member continues to be at risk for relapse based on current clinical assessment, history, or the tenuous nature of the functional gains **and** anyone **(1-5)** of the following:

**1.** The member has *achieved* current treatment plan goals **and** additional goals are indicated and evidenced by documented symptoms, or;

**2.** The member is making *satisfactory progress* toward meeting goals, **and** there is documentation that supports continuation of ACT will be effective in addressing the goals outlined in the treatment plan, or;

**3.** The member is making *moderate progress*, but the specific interventions in the treatment plan need to be modified so that greater gains, which are consistent with the member's pre-morbid or potential level of functioning, are possible, or;

**4.** If the member fails to make progress or demonstrates regression in meeting goals through the interventions outlined in the treatment plan, then **one** (**a or b**) of the following must be documented:

**a)** There is documentation that the member's diagnosis was reassessed to identify any unrecognized co-occurring disorders and new treatment is based on findings, or;

***b)*** If no new co-occurring disorders are indicated, the new treatment plan is updated with new goals and/or interventions **and** the treating provider must clearly indicate why they believe continuing ACT with the new treatment plan will be effective. If approved under this criterion, then **both** (**i and ii**) of the following must apply:

**i.** Duration of approval cannot exceed 90 days, and;

**ii.** To extend the approval another 90 days (to equal the full 6-month total), the 90-day progress summary of the revised and valid IPOC needs to be submitted for review by our medical director **and** must clearly show that member is making at least moderate progress of the revised treatment plan.

**5.** If the member is functioning effectively with the ACT and discharge would otherwise be indicated, the ACT team services must be maintained when it can be reasonably anticipated that regression is likely to occur if the service is withdrawn. The decision must be based on **one (a or b)** of the following:

**a)** The member has a documented history of regression in the absence of ACT services or attempts to titrate ACT team services downward have resulted in regression, or;

**b)** There is an epidemiologically sound expectation that symptoms will persist, and ongoing outreach treatment interventions are needed to sustain functional gains.

**IV.** Member meets **discharge criteria** for Assertive Community Treatment (ACT) services when at least **one** of the following is met:

**A.** The member and team determine that ACT services are no longer needed based on achievement of goals as identified in the IPOC and a less intensive level of care would adequately address current goals. Standards for transitioning to fewer intensive services should

be consistent with the standards noted in Operations and Structure 9 (OS9) on the TMACT OS subscale.

**B.** The member moves out of the catchment area and the ACT team has facilitated the referral to either a new ACT provider or other appropriate mental health service in the new place of primary private residence and has assisted the beneficiary in the transition process. The ACT shall maintain documentation of the referral process.

**C.** The member, and if appropriate, the legally responsible person chooses to withdraw from services and documented attempts by the program to re-engage the beneficiary have not proven to be successful.

**D.** The member has not demonstrated significant improvement following reassessment, several adjustments to the IPOC over a minimum of a three-month period and all engagement strategies have been documented with no demonstrable results, and:

1. Alternative treatment or providers have been identified that are deemed necessary and are expected to result in greater improvement as determined by the team's clinical judgement.
2. The member's behavior has worsened, such that the continued treatment is not anticipated to result in sustainable change as determined by the team's clinical judgement.
3. More intensive levels of care are indicated by the team's clinical judgement.

**V.** It is the policy of Absolute Total Care that current evidence does not support the safety and efficacy of ACT services as clinically appropriate, is not medically necessary, and cannot be authorized and/or reimbursed in **any** of the following conditions:

**A.** Members younger than 18 years of age or older than 26 years of age at the time services are rendered.

**B.** Service authorization requests for less than a one (1) month duration, more than a six (6) months duration, or for durations in increments other than thirty (30) days.

**C.** Service authorization requests for a frequency of less than nine (9) days or more than fifteen (15) days per month. *Note: See "Other General Guidelines" for more information below. Per state Medicaid regulations, ACT providers are required to continue providing eligible ACT services to member even if maximum per diem limit for the month has been reached.*

**D.** ACT services (other than psychiatry services, when necessary) that are provided via telehealth.

**E.** Changes made to ACT that do not follow the requirements outlined in the provider contract, service manual, or ACT fidelity standards.

**F.** Services not in compliance with SCDHHS ACT service manual and not in compliance with fidelity standards.

**G.** Services provided that are not within the provider's scope of practice, not included in the approved ACT service description, services provided without prior authorization (retro authorization is prohibited for ACT services), and services not authorized on the member's ACT treatment plan.

**H.** Any intervention or contact not documented or consistent with the approved treatment/recovery plan goals, objectives, and approved services will not be reimbursed.

**I.** For any other request or ACT service that does not meet the applicable guidelines outlined in this policy using the above guidelines (I-IV) or information below.

**Background**

Assertive community treatment (ACT) refers to the evidence-based model of delivering comprehensive

community based behavioral health services to adults with certain serious and persistent mental illnesses who have not benefited from traditional outpatient treatment. Assertive community treatment (ACT) services are provided to an individual with a major functional impairment or behavior which present a high risk to the individual due to severe and persistent mental illness and which necessitate high service intensity. The desired outcome of ACT intervention is for the member/enrollee to achieve and maintain a stable life in the community-based setting, reduce the need for inpatient hospital admission and emergency department visits, improve mental and physical health status, and life satisfaction.

ACT uses a team treatment approach designed to provide comprehensive, community-based behavioral health treatment, rehabilitation, and support to persons with serious and persistent mental illness. Through this team approach, ACT services will help improve coordination of care. Through this model, providers will be reimbursed an all-inclusive daily rate for rendering services to Healthy Connections Medicaid members that may be currently receiving services that are billed as standalone RBHS services; utilizing the daily rate for ACT services precludes billing for any other behavioral health service.

ACT services are provided by a multidisciplinary team that must include the following types of providers:

- Psychiatric care provider (psychiatrist, advanced practice registered nurse [APRN], nurse practitioner [NP], physician assistant [PA]);
- ACT team leader — a qualified mental health professional (QMHP) with independent licensure (licensed independent social worker-clinical practice [LISW-CP], licensed professional counselor [LPC], licensed marriage and family therapist [LMFT], or licensed psychologist);
- Registered nurse (RN);
- Co-occurring disorder professional — a master's level licensed or certified addictions counselor;
- Certified peer support specialist (South Carolina certification);
- Vocational success specialist —must have a minimum of a bachelor's degree in a human services field, at least one year experience working with adults with serious mental illness, and at least six months experience providing employment or educational support;
- Mental health professional —must have a bachelor's degree in a human services field and one year experience working with the population served, *or* a master's degree in social work, counseling, psychology, or related field; and,
- Administrative assistant.

ACT teams provide in vivo, flexible service delivery in the person's environment, and are available for crisis management 24 hours per day, seven days per week. Additional guidance on how ACT teams must demonstrate 24-hour provision of crisis management services and flexible service delivery will be available in the RBHS provider manual published on The South Carolina Department of Health and Human Services (SCDHHS) website. Absolute Total Care follows SCDHHS practices, criteria, policies, and procedures for ACT services.

**Service Documentation**

Each provider is responsible for developing the IPOC. When the State agency refers for services and does not provide the IPOC, the ACT team must develop the IPOC. IPOC documentation must meet all SCDHHS and Absolute Total Care requirements and include IPOC components as described in the SCDHHS policy and procedure (P&P) RBHS manual. If these components are also listed on the

assessment, the assessment must be attached to the IPOC. It is important for overall health care and wellness issues to be addressed. Provider is expected to follow Absolute Total Care and state Medicaid clinical documentation requirements and record retention timeline. Pursuant to federal and state law and Centene and Absolute Total Care quality assurance and payment integrity policies, any services submitted for reimbursement are subject to forensic, clinical, and/or compliance audit review.

**Prior Authorization, Continuity of Care, and Reimbursement**
ACT services require prior authorization and concurrent reviews to ensure medical necessity. Prior authorization must include a recommendation for ACT services by a physician, NP, PA or licensed psychologist. Prior authorization submission information for Absolute Total Care members can be found in our provider billing manual and under provider resources on our public website at www.absolutetotalcare.com. When there is a conflict in information or process, SCDHHS' policies and procedures take precedence.

ACT is the most intensive community based-based service available and is an all-inclusive service. ACT teams may bill per diems per month per individual when all other requirements for a visit are met only if the ACT team meets fidelity and approved by the SCDHHS or their designee in accordance with state guidelines. For an ACT team per diem to be generated, a 15-minute or longer face-to-face contact that meets all other requirements must occur. A 15-minute contact is defined as lasting at least eight minutes. Group contacts alone are not permitted as a face-to-face contact for generating an ACT per diem rate. Group psychotherapy or group therapy is a form of psychotherapy in which one or more therapists treat a small group of clients together as a group. Practitioners may not bill for services included in the ACT per diem and also bill for that service outside of the per diem for enrolled beneficiaries (see below table).

Prior Authorization is not a guarantee of payment. Claim payment and reimbursement is contingent upon compliance with all internal and external billing guidelines established by law, regulation, guidance, policy, communication, publication, contract, or other appropriate guideline. Absolute Total Care has sole discretion in determining appropriateness of reimbursement in accordance with all state and federal regulations.

**General Guidelines for Other Services Provided Concurrently with ACT**

**Allowable:**

- Opioid Treatment, withdrawal management services, facility-based crisis, non-Medicaid funded evidenced based SE or long-term vocational supports, specialized clinical needs which cannot be provided among the team, SA residential treatment or Adult MH residential program, psychosocial rehabilitation for a 30-day transition period.

**Not Allowable**

- Individual, group, or family OP, OP medication management, OP psychiatric services, partial hospitalization, psychosocial rehabilitation after 30-day transition period, nursing home facility, Medicaid-funded evidenced based SE or long-term vocational supports, mobile crisis management.

**Other General Guidelines**

- ACT providers must continue to deliver medically necessary care for the remainder of the month even if the maximum monthly limit of fifteen (15) visits/days have been reached.
- The fidelity model also requires that services and supports outlined in the treatment plan continue to be

implemented even if beyond the minimum number of units permitted to be billed.

- Providers are prohibited from billing additional per diems and reimbursement will be denied for claims exceeding the monthly limit. Outliers and continuing to bill beyond the benefit limits may result in future claims being pended until a clinical review and audit can be completed and findings published.
- Billing is covered under code H0040 with a U1 modifier for small teams and a U3 modifier for large teams and is set on a per diem rate (refer to our claim, billing, payment, and coding policies for specific information on claim processing and reimbursement requirements).
- ACT per diems may only be billed on days when the ACT has performed a face-to-face with the member or a family member. Only one per diem may be billed per member, per day.
- Members that are authorized for ACT are not eligible to receive any other behavioral health service and ACT is the only service that can be reimbursed.
- Authorizations should not end early, nor can they be 'paused.' Additionally, ACT claims supersede all other behavior health claims.
- There are no restrictions for place of service limitations for ACT services. The ACT team is expected to meet with the member in their environment at any time of the day/week that honor the member's preferences and meet the members at home, in homeless shelters, streets, or hospitals. *Note: Other than psychiatry services, when necessary, ACT is not intended to be provided via telehealth.*

**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 2022, 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® / HCPCS® Codes | Description |
|---|---|
| H0039 | Assertive Community Treatment Face-to-Face, 15 min |
| H0040 | Assertive Community Treatment Program, Per Diem |
| ***Services that are included in the ACT Per diem rate and cannot be approved and/or reimbursed outside of the per diem for enrolled members*** | |
| ***Screening and Assessment Services*** | |
| H0002 | Behavioral Health Screening, 15 minutes |
| H0031 | Mental Health Comprehensive Diagnostic Assessment- Follow-up, Encounter |
| H0031 | Comprehensive Evaluation- Follow up, Encounter |
| H2000 | Comprehensive Evaluation- Initial, Encounter (average of 3 hours) |
| 90791 | Psychiatric Diagnostic Assessment without Medical Services – Initial, Encounter |
| 90792 | Psychiatric Diagnostic Assessment with Medical Services – Initial, Encounter |
| 96101 | Psychological Testing / Evaluation, 60 minutes |
| ***Service Plan Development*** | |
| H0032 | Mental Health Service Plan Development (Non-Physician), 15 minutes |

| | |
|---|---|
| 99366 | Service Plan Development (Team Conference w/ member/family), Encounter (minimum 30 minutes) |
| 99367 | Assertive community treatment program, per diem |
| ***Core Treatment- Psychotherapy and Counseling Services*** | |
| H0034 | Medication Management, 15 minutes |
| H2011 | Crisis Management, 15 minutes |
| 90832 | Individual Psychotherapy, 60+ minutes |
| 90846 | Family Psychotherapy w/o Client, 60+ minutes |
| 90847 | Family Psychotherapy w/ Client, 60+ minutes |
| 90849 | Multiple Family Group Psychotherapy, 60+ minutes |
| 90853 | Group Psychotherapy, 60+ minutes |
| ***Community Support Services*** | |
| H2014 | Behavior Modification (B-Mod), 15 minutes |
| H2017 | Psychosocial Rehabilitation (PRS), 15 minutes |
| H2030 | Community Integration Services, 15 minutes |
| H2037 | Therapeutic Child Care, 15 minutes |
| S5145 | Therapeutic Foster Care, Per diem |

| Reviews, Revisions, and Approvals | Revision D | Approval Date |
|---|---|---|
| New policy adapted based on South Carolina Department of Health and Human Services Medicaid Bulletin (MB# 23-028) published June 16, 2023. Policy is required to be fully live, implemented, and in full effect by 7/01/24. | 2/14/24 | 2/14/2024 |
| | | |

**References**

1. Rehabilitative Behavioral Health Services (RBHS) Provider Manual. The South Carolina Department of Health and Human Services (SCDHHS). November 1, 2023. Healthy Connections Medicaid. https://provider.scdhhs.gov/internet/pdf/manuals/RBHS/Manual.pdf.
2. SAMHSA. ACT: The Evidence. DHHS Pub. No. SMA-08-4344, Rockville, MD: Center for Mental Health Services, SAMHSA, U.S. Department of Health and Human Services, 2008.

**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 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/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees 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.



**Note: For Medicaid members/enrollees**, 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/enrollees,** 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.