Optum

Fax request to: Optum Public Sector San Diego
Phone: (800) 798-2254, option 3 then 4
Fax: (866) 887-2983

County of San Diego Behavioral Health Plan

Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT) Prior Authorization Request

- ☐ Prior Authorization Request
- ☐ Step-up Request from ICM to ACT (same program only)
- ☐ Continuing Request
- ☐ Other Health Coverage (If applicable, include signed AOB with first request to Optum)

Client Information

Client Name:	Date of Birth:
Medi-Cal or Social Security Number:	Client SmartCare ID:

Program Information

Legal Entity:	Program Name:
Phone:	Fax:
Program Manager Name:	ACT or FACT Request: ☐ ACT ☐ FACT

ACT/FACT Criteria: (*1-10 are required, 9 required for FACT only*)

1. ☐ Member is age 18 or older (or TAY if permitted by contract)

2. ☐ Member is Medi-Cal eligible, has pending Medi-Cal eligibility, or meets income criteria up to 200% of the Federal Poverty Level (FPL).

3. ☐ Diagnosis (SMI Requirement): Member meets criteria for a Serious Mental Illness as evidenced by one or more of the following diagnoses:
   - ☐ Schizophrenia Spectrum or Other Psychotic Disorder
   - ☐ Bipolar I or II Disorder
   - ☐ Major Depressive Disorder with Psychotic Features
   - ☐ Other qualifying SMI diagnosis (specify):

   DSM Diagnosis Code(s):

4. Functional Impairment: Role Functioning Scale (RFS):
   - ☐ **Question #1 Independent Living / Self Care** *(Must be met by a score of 1 or 2)*
     Score:
   - ☐ **Question # 2 Immediate Social Network Relationships** *(Must be met by a score of 3 or lower)*
     Score:

5. High Acuity / High Utilization Criteria: Member meets one or more of the following:
   High use of psychiatric hospitalization or psychiatric emergency services as defined by one of the criteria below:
   - ☐ Psychiatric inpatient (minimum of 1), or CSU admissions (minimum of 1), or an extended inpatient stay (14+ days) in the past 6 months
   - ☐ Multiple PERT or MCRT contacts (minimum of 2) in the past 6 months
   - ☐ Discharged directly from a State Hospital or MHRC/STP with a clinical assessment that, despite stabilization, cannot be safely maintained in a lower-intensity setting
   - ☐ Intractable (persistent or recurrent) severe major psychiatric symptoms (e.g., affective, psychotic, suicidal)
   - ☐ Co-existing SUD of significant duration
   - ☐ High-risk or a recent history of being involved in the criminal justice system
   - ☐ Living in sub-standard housing, experiencing homelessness, or at imminent risk of becoming homeless
   - ☐ Clinically assessed to be able to live more independently if intensive psychiatric services are provided
   - ☐ Inability to participate in office-based services

6. Most recent Level of Care Utilization System (LOCUS) score must be 4 or higher.
   Date of LOCUS: _____ Score: _____

7. ☐ Medical Necessity Statement: Based on the information above, ACT/FSP II services are medically necessary to prevent psychiatric decompensation, reduce hospitalization and crisis utilization, support housing stability, and improve functional outcomes. The member requires an intensive, multidisciplinary, field-based approach consistent with the ACT model and FSP II population criteria.

8. ☐ Member is willing to participate voluntarily in ACT/FSP II services (unless on LPS Conservatorship).

9. **FACT ONLY:** Have lived experience with the criminal justice system in at least ONE of the following:
   - ☐ Released from a correctional facility within the last 12 months (e.g., prison, jail, youth correctional facility)
   - ☐ Are at high risk of criminal justice involvement (e.g., previous arrest, on diversion, or in mental health collaborative courts)

10. SMHP Clinician is requesting ACT/FACT services: (*Must check all 3* for amount, scope & duration)
    - ☐ A minimum of 4 contacts on 4 different days a month and at least 3 contacts are delivered face-to-face – **Amount**
    - ☐ Assertive Community Treatment – **Scope**
    - ☐ Up to 6 months of ACT/FACT Intervention – **Duration**

FOR USE BY OPTUM ONLY/AUTHORIZATION DETERMINATION

☐ OPTUM Reviewed 1-10
☐ ACT/FACT scope, amount and duration authorized as requested: Start Date: _____ End Date: _____
☐ ACT/FACT request is ☐ denied; ☐ modified; ☐ reduced; ☐ terminated; or ☐ suspended
Reason: _____

NOABD was issued to the Medi-Cal beneficiary and provider on the following date: _____
Optum Clinician Signature/Date/Licensure:

Within five business days of Optum receipt, authorization will be forwarded to the requesting provider