Clinical Policy: Assertive Community Treatment (ACT)

Reference Number: OH.CP.BH.501 Coding Implications
Date of Last Revision: 10/24 Revision Log

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

Description

This clinical policy outlines the utilization management of authorization requests for Assertive community treatment (ACT) services within Buckeye Health Plan based off Ohio Legislative Service Commission. Ohio Laws and Administrative Rule 5160-27-04: Mental health assertive community treatment service and Ohio Legislative Service Commission. Ohio Laws and Administrative Rule 5122-29-29: Assertive community treatment (ACT).

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.[1]

The purpose of ACT team services is to provide the necessary services and supports which maximize recovery, and promote success in employment, housing, and the community. This service is available twenty-four hours a day, seven days a week.[2]

Policy/Criteria

I. It is the policy of Buckeye Health Plan and Centene Advanced Behavioral Health that a medical director will review requests for Assertive Community Treatment (ACT) services, on a case-by-case basis, when meeting all the following:
   A. Member/enrollee is ≥ 18 years old at the time of enrollment;
   B. The member/enrollee has a confirmed primary diagnosis of one of the following mental health disorders as listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM):
      1. Schizophrenia spectrum;
      2. Bipolar disorder;
      3. Major depressive disorder (MDD) with psychosis;
   C. Request is for ≤12 months of ACT;
   D. Required documentation, one of the following:
      1. Member/enrollee receives supplemental security income or has a social security disability insurance determination;
      2. An Adult Needs and Strengths Assessment (ANSA) was administered by an individual with a bachelor's degree or higher *and* the score demonstrates one of the following results:
         a. A score of *two or greater* on at least one of the items in the Mental Health Needs or Risk Behaviors sections of the ANSA;
         b. A score of *three* on at least one of the items in the Life Domain Function section of the ANSA;
   E. The member/enrollee meets one or more of the following:
      1. significant others who are part of the recipient's support network;

1. Has had two or more admissions to a psychiatric inpatient hospital setting during the past 12 months;
2. Has had two or more occasions of utilizing psychiatric emergency services during the past 12 months;
3. Has demonstrated significant difficulty meeting basic survival needs within the last 24 months;
4. Has history within the past two years of criminal justice involvement including but not limited to any of the following:
   a. Arrest;
   b. Incarceration,
   c. Probation;

F. The member/enrollee meets one or more of the following:
1. Persistent or recurrent severe psychiatric symptoms;
2. Coexisting substance use disorder of more than six months in duration;
3. Residing in an inpatient or supervised residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided;
4. At risk of psychiatric hospitalization, institutional or supervised residential placement if more intensive services are not available;
5. Unsuccessful in using traditional office-based outpatient services in the past;

G. The ACT team is the sole provider of outpatient behavioral health services, including level one outpatient services;

H. The ACT team has a designated team lead who has psychiatric training and holds one of the following valid licenses from the appropriate Ohio professional licensure board or licensure equivalents for ACT teams located in other states. Note: Team leaders who are licensed in accordance with paragraph (A)(5) of Rule 5160-27-01 of the Administrative Code but do not have independent licensure status from one of the boards referenced must receive approval from ODM before the ACT team to which they are assigned can begin billing Ohio Medicaid:
1. Licensed independent social worker;
2. Licensed independent marriage and family therapist;
3. Licensed professional clinical counselor;
4. Licensed psychologist;
5. Physician medical doctor, psychiatrist, doctor of osteopathy;
6. Clinical nurse specialist;
7. Certified nurse practitioner;
8. Physician assistant;
9. Registered nurse;

I. Planned ACT services include, but are not limited to, any of the following:
2. Psychiatry and primary care as related to the mental health or substance use disorder diagnoses;
3. Service coordination;
4. Crisis assessment and intervention;
5. Symptom assessment and management;

6. Community based rehabilitative services;

Education, support, and consultation to families, legal custodians, and

J. Planned ACT services do not include the following (not all-inclusive):
   1. Time spent attending or participating in recreational activities;
   2. Services provided to teach academic subjects or as a substitute for educational personnel; including but not limited to a teacher, teacher's aide, or an academic tutor;
   3. Habilitative services for the recipient to acquire, retain, and improve the self-help, socialization, and adaptive skills necessary to reside successfully in community settings;
   4. Childcare services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision;
   5. Respite care;
   6. Transportation for the recipient or family;
   7. Services provided to children, spouse, parents, or siblings of the eligible recipient under treatment or others in the eligible recipient's life to address problems not related to the eligible recipient's issues and not listed in the eligible recipient's ACT treatment plan;
   8. Art, movement, dance, or drama therapies;
   9. Services provided to collaterals of the recipient;
   10. Any service outside the responsibility of the ACT team;
   11. Vocational training and supported employment services, unless the member/enrollee is enrolled in the specialized recovery services program as described in Ohio Laws and Administrative Rule 5160-43-01;
   12. Crisis intervention provided by the provider agency employing the ACT team;
K. Treatment plan meets the requirements noted in Ohio Laws and Administrative Rule 5160-08-05 and all the following:
   1. Individualized and based on the member/enrollee's needs, strengths, and preferences;
   2. Contains measurable long term and short-term goals;
   3. Identifies specific approaches and interventions;
   4. Identifies who will carry out the approaches and interventions;
   5. Addresses, but is not limited to, any of the following key areas:
      a. Psychiatric illness or symptom reduction;
      b. Substance treatment services;
      c. Stable, safe, and affordable housing;
      d. Activities of daily living;
      e. Daily structure and activities (including employment if appropriate);
      f. Family and social relationships;
   6. Reviewed and signed by the member/enrollee and the ACT team practitioner;
L. For *continued stay requests,* treatment plans additionally meet all of the following:
   1. Reviewed and revised at a minimum of every six months or when a change is needed;
   2. Documentation includes all of the following:
      a. Member/enrollee's progress or lack of progress with goals;

b. Goal attainment;
c. Effectiveness of intervention;
d. Member/Enrollee's satisfaction with the ACT team interventions since implementation of the previous treatment plan.

II. It is the policy of Buckeye Health Plan and Centene Advanced Behavioral Health that Assertive Community Treatment (ACT) services may no longer be considered medically necessary when meeting one of the following:

A. Disenrollment is *planned* and meets both of the following:
   1. Due to one of the following circumstances:
      a. The member/enrollee has successfully met established goals and the member/enrollee, and/or their guardian and ACT team members agree to the discharge from ACT;
      b. The member/enrollee moves outside the geographic area of the ACT team's responsibility. Note: The ACT team should arrange to transfer mental health and substance use disorder service responsibility to another ACT program or other provider;
      c. The member/enrollee or guardian requests disenrollment;
      d. The member/enrollee no longer meets eligibility or medical necessity criteria for ACT;
   2. Documentation that the member/enrollee and/or guardian, has actively participated in the disenrollment process, including all of the following:
      a. The reason(s) for the member/enrollee's disenrollment;
      b. Progress toward the goals set forth in the treatment plan;
      c. Behavioral health care is being linked and transferred to an alternative provider;
      d. Signatures of the member/enrollee or their guardian, the ACT team leader, and the psychiatric prescriber;

B. *Unplanned disenrollment* meets one of the following:
   1. The ACT team is unable to locate the member/enrollee for more than 45 days;
   2. The member/enrollee is incarcerated, hospitalized, or admitted to a residential substance use disorder treatment facility.

Background

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.[2] 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.[1]

The Assertive Community Treatment (ACT) model utilizes a multidisciplinary team of practitioners to deliver services to eligible individuals. Prior authorization must

demonstrate eligibility for ACT services as specified in Ohio Admin Code 5160-27-04. Requests must be accompanied by the appropriate documentation which includes, but is not limited to, the Adult Needs and Strengths Assessment (ANSA) results or the documentation that supports the social security determination.[1]

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 2023, 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.

HCPCS ®* Codes	Description
H0039	Assertive community treatment, face-to-face, per 15 minutes
H0040	Assertive community treatment program, per diem

Reviews, Revisions, and Approvals	Revision Date	Approval Date
New policy adapted based off Ohio Administrative Rule 5122-29-29: Assertive community treatment (ACT) and Ohio Administrative Rule 5160-27-04: Mental health assertive community treatment service.	06/23	06/23
Removed description statement regarding 24/7 availability of services. Added section describing desired treatment outcomes in I.J, with related addition to the background. Clarified in I.H. that "ACT services include, but are not limited to, any of the following, as needed."	07/23	07/23
Added I.D to separate the criteria points referencing SSI/SSDI and ANSA scores to read as "Required documentation, one of the following" as listed in the Ohio Administrative Rule 5160-27-04. Added I.J.6 in reference to the treatment plan "Reviewed and signed by the member/enrollee and the ACT team practitioner." References reviewed and added an additional reference: "Ohio Legislative Service Commission. Ohio Laws and Administrative Rule 5160-08-05: Behavioral health services- other licensed professionals."	08/23	08/23
Annual Review. Description section updated. Policy restructured and reformatted. Reordered and reorganized criteria for clarity. Minor wording changes made for clarity. Removed redundant language. Added I.G. and I.H. referencing ACT team service provider requirements. Added I.L. to address "continued stay request criteria." Added a new policy statement II. to address reasons why ACT services may no longer be considered medically necessary. Background section reviewed and updated. References reviewed and updated.	10/24	12/24

References

1. Ohio Legislative Service Commission. Ohio Laws and Administrative Rule 5160-27-04: Mental health assertive community treatment service. https://codes.ohio.gov/ohio-administrative-code/rule-5160-27-04. Updated January 1, 2021. Accessed October 17, 2024.
2. Ohio Legislative Service Commission. Ohio Laws and Administrative Rule 5122-29-29: Assertive community treatment (ACT). https://codes.ohio.gov/ohio-administrative-code/rule-5122-29-29. Updated November 21, 2020. Accessed October 17, 2024.
3. Ohio Legislative Service Commission. Ohio Laws and Administrative Rule 5160-27-01: Eligible provider of community behavioral health services. https://codes.ohio.gov/ohio-administrative-code/rule-5160-27-01.Updated October 1,2024. Accessed October 17, 2024.
4. Ohio Legislative Service Commission. Ohio Laws and Administrative Rule 5160-08-05: Behavioral health services- other licensed professionals. https://codes.ohio.gov/ohio-administrative-code/rule-5160-8-05. Updated January 01, 2021. Accessed October 17, 2024.
5. Ohio Legislative Service Commission. Ohio Laws and Administrative Rule 5160-43-01: Specialized recovery services program definitions. https://codes.ohio.gov/ohio-administrative-code/rule-5160-43-01. Updated September 01, 2024. Accessed October 17, 2024.

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.

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/enrollees, 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/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

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.