

## Clinical Policy: Assertive Community Treatment (ACT)

Reference Number: OH.CP.BH.501

Date of Last Revision: 08/25

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### Description

This clinical policy outlines the medical necessity criteria for Assertive Community Treatment (ACT) services within Buckeye Health Plan based off guidance from the Ohio Legislative Service Commission and in accordance with Ohio Administrative Rules 5160-27-04: Mental health assertive community treatment service and 5122-29: 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.<sup>1</sup>

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

### Policy/Criteria

- I. It is the policy of Buckeye Health Plan and Centene Advanced Behavioral Health that requests for Assertive Community Treatment (ACT) services, are considered medically necessary when meeting all of the following:
  - A. Member/enrollee is  $\geq 18$  years old at the time of enrollment;
  - B. 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. One of the following is met:
    1. Member/enrollee receives Supplemental Security Income (SSI) or has a determination of eligibility for Social Security Disability Insurance (SSDI);
    2. Member/enrollee's Adult Needs and Strengths Assessment (ANSA) results demonstrate one of the following:
      - a. A score of *two or higher* on at least one of the items in the Mental Health Needs or Risk Behaviors section;
      - b. A score of *three* on at least one of the items in the Life Domain Function section;
  - D. Member/enrollee meets one or more of the following:
    1. Two or more admissions to a psychiatric inpatient hospital setting during the past 12 months;
    2. Two or more occasions of utilizing psychiatric emergency services during the past 12 months;

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3. Demonstrated significant difficulty meeting basic survival needs within the last 24 months;
  4. 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;
- E. Member/enrollee exhibits 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. Risk of psychiatric hospitalization, institutional or supervised residential placement if more intensive services are not available;
  4. Lack of success with traditional office-based outpatient services in the past;
  5. Currently resides in an inpatient or supervised residential setting, but has been clinically assessed as capable of living in a more independent living situation if intensive services are provided;
- F. Request for services includes one of the following:
1. *Initial admission* meets all of the following:
    - a. Criteria I.A. through I.E., are met;
    - b. The service request is for  $\leq 12$  months of ACT;
    - c. Treatment plan, completed within five sessions or one month of admission meets, all of the following:
      - i. Individualized and based on the member/enrollee's needs, strengths, and preferences;
      - ii. Contains measurable long term and short-term goals;
      - iii. Identifies specific approaches and interventions;
      - iv. Identifies who will conduct the approaches and interventions;
      - v. Addresses, at minimum, 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;
      - vi. Reviewed and signed by the member/enrollee and the ACT team practitioner;
    - d. ACT services include, but are not limited to, any of the following:
      - i. Psychiatry and primary care as related to mental health or substance use disorder diagnoses;
      - ii. Service coordination;
      - iii. Crisis assessment and intervention;
      - iv. Symptom assessment and management;
      - v. Community based rehabilitative services;
      - vi. Education, support, and consultation to families, legal custodians, and significant others who are part of the member/enrollee's support network;
    - e. The ACT team is the sole provider of outpatient behavioral health services, including level one outpatient services;
    - f. The ACT team has a designated team leader who has psychiatric training and holds one of the following valid licenses from the appropriate Ohio

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professional licensure board or licensure equivalents for ACT teams located in other states.

- i. Licensed independent social worker;
  - ii. Licensed independent marriage and family therapist;
  - iii. Licensed professional clinical counselor;
  - iv. Licensed psychologist;
  - v. Physician medical doctor, psychiatrist, doctor of osteopathy;
  - vi. Clinical nurse specialist;
  - vii. Certified nurse practitioner;
  - viii. Physician assistant;
  - ix. Registered nurse;
2. *Continued stay request* includes all of the following:
- a. Member/enrollee continues to meet the admission criteria noted in I.F.1.;
  - b. The treatment plan is reviewed and revised, at a minimum, every six months or when a change is needed and meets the following:
    - i. The criteria noted in I.F.1.c. continue to be met;
    - ii. The plan is reviewed and signed by the member/enrollee and the ACT team practitioner;
  - c. Frequency of service is for a minimum of 90 days or until the member/enrollee has stated a desire to discontinue services;
  - d. Progress summary includes all of the following:
    - i. Member/enrollee's progress or lack of progress with goals;
    - ii. Goal attainment;
    - iii. Effectiveness of intervention;
    - iv. 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 **discharge** from Assertive Community Treatment (ACT) services meets 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 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;

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- d. Signatures of the member/enrollee or their guardian, the ACT team leader, and the psychiatric prescriber;
- B. *Disenrollment is unplanned and* 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 an elevated risk to the individual due to severe and persistent mental illness and which necessitate high service intensity. ACT services are also provided to the individual's family and other support systems.<sup>2</sup> 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.<sup>1</sup>

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.<sup>1</sup>

**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 2024, 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

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Reviews, Revisions, and Approvals	Revision Date	Approval Date
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
Annual review. Minor restructuring and rewording throughout the policy. Added I.F. "request for services...". Added I.F.1. "Initial admission meets...". Added I.F.1.c."treatment plan, completed within five sessions...". Added I.F.2.c. "Frequency of service is for a minimum of 90 days...". Added I.F.2.d. "progress summary...". Added "discharge" to policy statement II. Removed former I.J. “Planned ACT services do not include....” Background updated. References reviewed and updated.	08/25	

**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 August 11, 2025.
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 August 11,2025.
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 August 11,2025.
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 August 11,2025.
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 August 11, 2025.

**Important Reminder**

## CLINICAL POLICY ASSERTIVE COMMUNITY TREATMENT (ACT)

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.

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**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.

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