Clinical Policy: Assertive Community Treatment (ACT)

Reference Number: SC.CP.BH.500
Date of Last Revision: 03/25

Coding Implications
Revision Log

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

Description

This clinical policy describes the medical necessity criteria for Assertive Community Treatment (ACT) for Absolute Total Care, Healthy Connections as outlined by the South Carolina Department of Health and Human Services (SCDHHS).

Assertive Community Treatment (ACT) is a best-practice, community-based treatment for members with severe mental illness (SMI). ACT is an intensive, non-residential treatment and rehabilitative mental health service that assists members with decreasing psychiatric hospitalizations and involvement with law enforcement while increasing their community living skills. ACT services provide a single, fixed point of responsibility for treatment, rehabilitation, and support needs for members who require a higher level of community care and have not been well supported in lower level of care options.

Policy/Criteria

I. It is the policy of Absolute Total Care and Centene Advanced Behavioral Health that *initial requests* for assertive community treatment (ACT) services are considered **medically necessary** when meeting all the following are met:

A. Member/enrollee is 18 years of age or older;
B. Services will be provided at least 9 days but no more than 15 days per month;
C. Member/enrollee has a confirmed primary diagnosis, per the most recent edition of the Diagnostic and Statistical Manual (DSM), of one of the following:
   1. Schizophrenia;
   2. Bipolar disorder;
   3. Other psychotic disorders (e.g., schizoaffective disorders);
   4. Other psychiatric illnesses, eligible depending on level of long-term disability from mental illness (unless otherwise noted below);
D. Diagnosis reflects a serious and persistent mental illness with the need for treatment and requested services are reasonably expected to meet the member/enrollee's specific preventive, diagnostic, therapeutic, or rehabilitative needs;
E. Member/enrollee has significant functional impairment as demonstrated by at least one of the following:
   1. Significant difficulty consistently performing 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, nutritional needs, personal hygiene) or persistent or recurrent difficulty performing daily living tasks without significant support or assistance from others;
   2. Significant difficulty maintaining consistent employment at a self-sustaining level or significant difficulty consistently carrying out 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. At least one of the following indications of continuous high service needs:
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 or 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 a residential or institutional placement if more intensive services are not available;
7. Difficulty effectively using traditional office-based outpatient services.

II. It is the policy of Absolute Total Care and Centene Advanced Behavioral Health that requests for *continued assertive community treatment (ACT) services* are considered medically necessary when meeting all of the following:

A. The individualized plan of care (IPOC) has been submitted and meets the documentation requirements set by the South Carolina Department of Health and Human Services;
B. Member/enrollee continues to be at risk for relapse based on current clinical assessment, history, or the desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the treatment plan, as evidenced by at least one of the following:
1. Current treatment plan goals have been achieved, and additional goals are indicated as evidenced by documented symptoms;
2. Satisfactory progress is being made toward meeting goals outlined in the treatment plan and documentation supports that continued ACT services will be effective in addressing those goals;
3. Moderate progress is being made but specific interventions in the treatment plan need to be modified for greater gains to be made, consistent with the member/enrollee's pre-morbid or potential level of functioning;
4. Member/enrollee fails to make progress or demonstrates regression in meeting goals through the interventions outlined in the treatment plan and both of the following:
a. Diagnosis has been reassessed to identify any unrecognized co-occurring disorders;
b. Treatment plan has been updated based on the findings;
5. Member/enrollee is functioning effectively with ACT services and discharge would otherwise be indicated, but regression is reasonably anticipated if services are withdrawn based on one of the following:
a. Documented history of regression in the absence of ACT team services or

attempts to titrate ACT team services have resulted in regression;

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

III. It is the policy of Absolute Total Care and Centene Advanced Behavioral health that assertive community treatment services may be appropriate for *transition/discharge*, for any of the following indications:

A. Goals identified in the individual plan of care (IPOC) have been achieved and a less intensive level of care would adequately address current goals;

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 provider shall maintain documentation of the referral process.

C. Member and legal guardian, if applicable, choose to withdraw from services and documented attempts at reengagement in the program have not been successful;

D. No significant improvement following reassessment, adjustments to the IPOC over a minimum of a three-month period, and all engagement strategies have been documented without demonstrable results, and any of the following:

1. Alternative treatment or providers have been identified and are deemed necessary and with greater improvement reasonably anticipated;
2. Behaviors have worsened, such that continued treatment is not anticipated to result in sustainable change;
3. More intensive levels of care are indicated.

Background

South Carolina Department of Health and Human Services- Rehabilitative Behavioral Health Services (RBHS) Provider Manual

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. Typically, those served through ACT have a treatment history characterized by frequent use of psychiatric hospitalization and emergency rooms, involvement with the criminal justice system, substance use, and lack of engagement in traditional outpatient services. 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, providing improved coordination of care. ACT services help to improve coordination of care by utilizing a multidisciplinary team that includes 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;
- 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.

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.

Prior Authorization, Continuity of Care, and Reimbursement
ACT is the most intensive community 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. 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).

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 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.
- 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.

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
H0040	Assertive community treatment program, per diem (*U1 modifier should be included for small teams and U3 modifier for large teams)*

Reviews, Revisions, and Approvals	Revision Date	Approval Date
New policy based off the South Carolina Department of Health and Human Services Medicaid Bulletin (MB# 23-028) June 2023.	02/24	02/24

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Annual review. Description updated with no impact to criteria. Criteria reworded and restructured throughout policy for clarity. Removed previous criteria under I.C. " ...does not have a primary diagnosis...". Moved and reworded previous criteria under I.D. " request is for..." to I.B. "Services will be provided at least...". Added clarifying language to I.F. "...by at least one (1-7)". Remove former criteria noted in II, II.A. and II.B. and replaced it with clarifying language regarding documentation requirements for continued services. Added II.A. " the individualized plan of care...". Moved previous criteria III.D. "the desired outcome of level of..." to II.B., with minor rewording for clarity. Moved previous policy statement IV. regarding discharge criteria to policy statement III. Removed former policy statement V "...the current evidence does not support the safety and efficacy...". Background updated with no impact to criteria. Removed service code H0039 and codes referencing services that are included in the ACT per diem rate. References reviewed and updated.	03/25	

References

1. South Carolina Department of Health and Human Services. Rehabilitative Behavioral Health Services (RBHS) Provider Manual. https://provider.scdhhs.gov/internet/pdf/manuals/RBHS/Manual.pdf. Updated January 1, 2025. Accessed February 3, 2025.
2. Substance Abuse and Mental Health Services Administration (SAMHSA). Assertive Community Treatment (ACT) Evidence-Based Practices (EBP) KIT. Website. https://www.samhsa.gov/resource/ebp/assertive-community-treatment-act-evidence-based-practices-ebp-kit. Accessed February 3, 2025.

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.