Sentara® Health Plans

Medicaid

Assertive Community Treatment (ACT), BH 28

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All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual*.

Description & Definitions:

Commonwealth of Virginia. Department of Medical Assistance Services. Mental Health Services (formerly CMHRS) – Appendix E: Intensive Community Based Support p. 2 (1/16/2025)

Assertive Community Treatment (ACT) is a highly coordinated set of services offered by group of medical, behavioral health, peer recovery support providers and rehabilitation professionals in the community who work as a team to meet the complex needs of individuals with severe and persistent mental illness. Assertive Community Treatment (ACT) provides long term needed treatment, rehabilitation, and support services to assist individuals in advancing toward personal goals with a focus on enhancing community integration and regaining valued roles (e.g. worker, daughter, resident, spouse, tenant, or friend). Assertive engagement techniques including rapport-building strategies, facilitating the meeting of basic needs, and motivational interviewing interventions are used to identify and focus on the individuals' life goals and motivations to change.

ACT is intended for individuals that have severe symptoms that are not effectively remedied by standard outpatient treatments or who because of reasons related to their mental illness challenge or avoid engagement with mental health services in the community. ACT services are offered to individuals in their natural environment and community. An individual who is appropriate for ACT requires this comprehensive, coordinated approach as opposed to participating in services across multiple disconnected providers, to minimize risk of hospitalization, homelessness, substance use, victimization, and incarceration.

Critical features of ACT include:

- A fundamental charge of ACT is to be the first-line (and generally sole provider) of all the services that an individual receiving ACT needs;
- Shared decision-making model, assistance with accessing medication, medication education, and assistance to support skills in taking medication with greater independence;
- Team staff availability either directly or on-call 24 hours per day, seven days per week and holidays;

- Crisis intervention that is available 24 hours per day, seven days per week, including holidays, via telephone and face-to face contact;
- Team provides a higher frequency and intensity of contacts with the individual with a staff-to-individual ratio no greater than 1:9;
- Team provides services that are community based, flexible and appropriately adjusted based on the individuals evolving needs;
- Being the single point of responsibility necessitates a higher frequency and intensity of community-based contacts between the team and individual, and a very low individual-to-staff ratio.
- ACT services are flexible and personalized, adjusting service levels to reflect needs as they change over time.
- Treatment planning

ACT teams must offer and have the capacity to provide the following covered service components to address the treatment needs identified in the initial comprehensive needs assessment:

- Assessment
- Crisis intervention
- Group Therapy*
- Health literacy counseling (all interventions related to medication management)
- Individual and Family Therapy
- Integrated dual disorders treatment for co-occurring substance use *
- Peer recovery support service;*
- Skills restoration
    - Social Skills
    - Communication skills
    - Problem solving skills
    - Wellness self-management and prevention
    - Symptom management
    - Skills required for activities of daily and community living
    - Service components of housing and tenancy sustaining services, pre-employment services and employment sustaining services that involve skills restoration activities such as assistance with social skills, communication skills, problem solving skills and community living skills necessary for an individual to be successful within these activities can be covered when provided by an ACT Team member who meets the staff qualifications for skills restoration (see staff requirements section).
- Treatment planning
- ACT service coordination (care coordination) consisting of facilitating access to:
    - Employment and vocational services
    - Housing access & support
    - Other services based on client needs as identified in the Individualized
    - Service Plan (ISP)

*As clinically indicated and supported by staff capacity and individual engagement, these services components can be provided in an individual and/or group setting.

Criteria:

Mental Health Services – Appendix E: Intensive Community Based Support p. 07 (1/16/2025)

Assertive Community Treatment (ACT) is considered medically necessary for **ALL** of the following:

- Treatment is for **1 or more** of the following:
    - Initial Care with **ALL** of the following:
        - 1. The individual must be 18 years or older (as required by EPSDT, youth below age 18 may receive ACT if medically necessary)
        - 2. The individual must have a documented DSM diagnosis that is consistent with a serious and persistent mental illness, including but not limited to, the following DSM categories: Schizophrenia

Spectrum and Other Psychotic Disorders; and, Bipolar and Related Disorders. Individuals with diagnoses that fall outside of these categories may be eligible depending on the level of associated long-term disability; in these cases, a Physician letter justifying this exception should accompany the service authorization request.

- 3. Individual has significant functional impairment as demonstrated by at least **1 or more** of the following:
  - a. Significant difficulty in consistent performance of the range of routine daily tasks required for basic adult functioning in the community (for example, 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)
  - b. Significant difficulty maintaining consistent employment at a self-sustaining level; or
  - c. significant difficulty consistently carrying out the head-of-household responsibilities (such as meal preparation, household tasks, budgeting, or child-care tasks and responsibilities)
  - d. Significant difficulty maintaining a safe living situation (for example, repeated evictions or loss of housing or utilities)
- 4. The individual has high service needs as indicated by **1 or more** of the following:
  - a. High use of acute psychiatric hospital as defined by multiple admissions within the past two years.
  - b. At least one recent long-term stay of 30 days or more in an acute psychiatric hospital inpatient setting within the last two years;
  - c. High use of behavioral health crisis services as defined by more than four interventions in the last 12 months;
  - d. Intractable (persistent or recurrent) severe psychiatric symptoms (affective, psychotic, suicidal, etc.)
  - e. Co-occurring mental health and substance use disorders of significant duration (more than 6 months)
  - f. High risk or recent history of criminal justice involvement (such as arrest, incarceration, probation) as a result of their mental health disorder symptoms
  - g. Significant difficulty meeting basic survival needs,
  - h. Residing in substandard housing, homelessness, or imminent risk of homelessness as a result of the individual's mental health disorder symptoms
  - i. Residing in an inpatient setting (e.g. state hospital or other psychiatric hospital) or supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided;
  - j. At Risk of requiring a residential or institutional placement if more intensive services are not available
  - k. Inability in consistent participation in traditional office-based outpatient services

- Continuation of services must meet **ALL** of the following:
  - 1. The individual continues to meet admission criteria
  - 2. Another less intensive level of care would not be adequate to support recovery
  - 3. ACT participation remains necessary due to continued risk that without the service, the individual is at risk for (any) **1 or more** following:
    - a. Compromised engagement in or ability to manage medication in accordance with ISP.
    - b. Increased use of crisis services
    - c. Inpatient psychiatric hospitalization
    - d. Decompensation of social and recreational skills (e.g. communication and interpersonal skills, forming and maintaining relationships)
    - e. Decompensation in functioning related to activities of daily living
    - f. Disruption in the individual's community supports due to individual's challenges with symptoms and functioning (Health, Legal, Transport, Housing, Finances, etc.);

        - g. Decompensation of vocational skills or vocational readiness
    - 4. The ISP includes evidence suggesting that the identified problems are likely to benefit from continued ACT participation and the goals are consistent with the components of this service
    - 5. The individual's natural supports, as appropriate, (e.g. individually identified-family/guardian/caregiver) are participating in treatment as clinically indicated and appropriate, or engagement efforts are underway
    - 6. Coordination of care and discharge planning are documented and ongoing from the day of admission with the goal of transitioning the individual to a less intensive level of care. These efforts should include communication with potential future service providers, community partners, and related resources related to school, occupational or other community functioning.

Discharge Guidelines:

Mental Health Services (formerly CMHRS) – Appendix E: Intensive Community Based Support p. 9 (1/16/2025)

The philosophy that guides the ACT model underscores that individuals participating in the service are expected to struggle with engagement given the severity of their mental illness. Individuals should not be discharged from the service due to perceived "lack of compliance" with the ISP or challenges integrating interventions into their lives towards recovery.

The individual meets discharge criteria if any **1 or more** of the following are met:

- The individual and team determine that ACT services are no longer needed based on the attainment of goals as identified in the ISP and a less intensive level of care would adequately address current goals
- The individual no longer meets admission/continued stay criteria and/or meets criteria for another level of care, either more or less intensive, and that level of care is sufficiently available
- Extenuating circumstances occur that prohibit participation including **1 or more** of the following:
    - Change in the individual's residence to a location outside of the service area
    - The individual becomes incarcerated or hospitalized for a period of a year or more
    - The individual chooses to withdraw from services and documented attempts by the program to re-engage the individual with the service have not been successful.

In circumstances where an individual is discharged from ACT because the individual becomes incarcerated or hospitalized, the provider is expected to prioritize these individuals for ACT services upon their anticipated return to the community, as long as the individual consents to returning to this service and ACT remains an appropriate and medically necessary service for the individual's needs.

Exclusions and Service Limitations: Commonwealth of Virginia. Department of Medical Assistance Services. Mental Health Services (formerly CMHRS) – Appendix E: Intensive Community Based Support p. 10 (1/16/2025)

In addition to the "Non-Reimbursable Activities for all Mental Health Services" section in Chapter IV of the DMAS manual, the following service limitations apply:

- An individual can only participate in ACT services with only one ACT team at a time.
- A service overlap with the services listed below is allowed with documented justification for time needed for admission or discharge transition planning and care coordination. Overlap durations will vary depending on the documented needs of the individual, the intensity of the services and any overlap limitation of the other service but in no instances may exceed 31 calendar days.
    - Applied Behavior Analysis
    - ARTS IOP or PHP
    - ARTS Level 3.1-3.7
    - Community Stabilization
    - Functional Family Therapy
    - Intensive In Home Services
    - Mental Health Intensive Outpatient
    - Mental Health Skill Building
    - Multisystemic Therapy
    - Outpatient Medication Management
    - Peer Recovery Support Services

    - Psychiatric Residential Treatment Facility
    - Therapeutic Day Treatment
    - Therapeutic Group Home (TGH)
- Standard Outpatient Individual, Group or Family Therapy: Additional overlap with outpatient individual, group or family therapy provided by an LMHP outside of the ACT team may be allowed with documented evidence that the therapy involves a treatment modality benefiting the individual that is not available within the ACT Team.
- Office based opioid treatment services (OBOT) and Office Based Addiction Treatment (OBAT) services are allowed simultaneously with ACT.
- If an individual is participating in ACT and has a concurrent admission to a Partial Hospitalization Program, the ACT team must conduct care coordination with those providers to assure alignment of the ISP and avoid any duplication of services.
- ACT does include non-job specific vocational training, employment assessments, and ongoing support to maintain employment. ACT may provide the necessary medical services that enable the individual to function in the workplace, including ACT services such as a psychiatrist's or psychologist's treatment, rehabilitation planning, therapy, and counseling or crisis management that enable the individual to remain in and/or function in the workplace.
- Individuals meeting any of the following are ineligible for ACT:
    - The individual's functional impairment is solely a result of a substance use disorder, personality disorder, developmental disability, traumatic brain injury or autism spectrum disorder without a co-occurring psychiatric disorder;
    - The individual is at imminent risk of harming self or others, or sufficient impairment exists that a more intensive level of service is required;
    - The individual's mental health disorder can be effectively treated or recovery process safely maintained at a less intensive level of care;
    - The individual requires a level of structure and supervision beyond the scope of the program;
    - The individual's primary problem is social, custodial, economic (i.e. housing, family conflict, etc.), or one of physical health without a concurrent mental health disorder meeting criteria for this level of care.

Document History:

Revised Dates:

- 2025: April – Updated to match DMAS Manual revision dated 1.16.2025. Effective date 7.1.2025.
- 2023: April
- 2022: April
- 2021: June, October

Reviewed Dates:

- 2026: April – Implementation date of August 1, 2026. DMAS manual has not updated. Update version number and reference only to reflect annual review.
- 2024: April

Origination Date: July 2021

Coding:

CPT/HCPCS codes considered **medically necessary** if policy criteria are met:

Coding	Description
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation with medical services
H0040	Assertive community treatment program, per diem

CPT/HCPCS codes considered **not medically necessary** per this policy:

Coding	Description
	None

The preceding codes are included above for informational purposes only and may not be all inclusive. Additionally, inclusion or exclusion of a treatment, procedure, or device code(s) does not constitute or imply member coverage or provider reimbursement.

Policy Approach and Special Notes:

- Coverage: See the appropriate benefit document for specific coverage determination. Member specific benefits take precedence over medical policy.
- Application to Products: This guideline is applicable to all Sentara Health Plan Virginia Medicaid products except Sentara Health Plan Virginia Medicaid FAMIS members.
- Authorization Requirements:
    - Initial registration is required by the Plan.
    - Commonwealth of Virginia. Department of Medical Assistance Services. Mental Health Services (formerly CMHRS) – Appendix E: Intensive Community Based Support p. 14 (1/16/2025)
    - ACT requires service authorization and the service providers delivering ACT shall meet the provider qualifications listed above.
    - Providers shall submit service authorization requests within one business day of admission for initial service authorization requests and by the requested start date for continued stay requests. If submitted after the required time frame, the begin date of authorization will be based on the date of receipt.
    - If additional ACT services are clinically required, the provider shall submit an authorization request to the FFS contractor or MCO through a continued stay service authorization request submitted no earlier than 24 hours before the requested start date of the continued stay and no later than the requested start date accompanied by the following items:
    - A Comprehensive Needs Assessment (see Chapter IV for requirements); and
    - A current addendum to the above assessment, (can be in a progress note) that briefly describes any new information impacting care, progress and interventions to date, and a description of the rationale for continued service delivery, and evidence the individual meets medical necessity criteria; and
    - Individual Service Plan
    - Required Activities: Mental Health Services (formerly CMHRS) – Appendix E: Intensive Community Based Support p.4 (1/16/2025). The following required activities apply to ACT:
        - **Assessment and Health Literacy Counseling:**
            - At the start of services, a LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner or Physician Assistant shall conduct an initial assessment consistent with the components required in the Comprehensive Needs Assessment (see Chapter IV for requirements), documenting the individual's diagnoses and describing how service needs match the level of care criteria.
                - If a nurse practitioner, who is not a psychiatric/mental health nurse practitioner or a physician assistant conducts the initial assessment it can only be used as the assessment for ACT and cannot be used as a comprehensive needs assessment by the provider for other mental health services (see Chapter IV for details).
            - A psychiatrist, psychiatric nurse practitioner or a nurse practitioner or physician assistant working under the supervision of a psychiatrist must provide the following:
                - A comprehensive psychiatric evaluation completed as soon as possible but no later than 30-calendar days after admission;
                - Medication prescription monitoring;
                - Contact with the individual, at a minimum, on a quarterly basis.
                - If an individual declines to participate in completing a comprehensive psychiatric evaluation, the team must document the attempt(s) and refusal(s) as well as ongoing efforts to engage the individual in this service component.

    - Participation of the psychiatrist or psychiatric nurse practitioner on the team must be documented such as involvement in team meetings, treatment planning, recommendations to improve psychiatric engagement, and assessment of medical and psychiatric needs.

- **Treatment Planning**:
    - Individual Service Plans shall be required during the entire duration of services and must be current. The initial treatment plan (ISP) shall be completed on the day of admission to the service.
    - ISPs must be reviewed as necessary at a minimum of every 30 calendar days or more frequently depending on the individual's needs. Refer to Chapter IV for additional guidance and documentation requirements for the 30 calendar day review as well as additional quarterly review requirements.
    - The treatment planning process should be collaborative but must be directed and authorized by a LMHP, LMHP-R, LMHP-RP, LMHP-S, nurse practitioner or physician assistant as evidenced by, at a minimum, the signature of the LMHP, LMHP-R, LMHP-RP, LMHPS, nurse practitioner or physician assistant.
- **Crisis Intervention:**
    - Crisis intervention must be available 24 hours per day, seven days per week, including holidays, via telephone and face-to face contact.
- **Peer Recovery Support Services:**
    - Registered peer recovery support specialists shall be a part of the ACT team with services to include coaching, consulting, wellness management and recovery strategies to promote recovery and self-direction. Registered peer recovery support specialists may also model and provide education on recovery principles and strategies to fellow team members. If a registered peer recovery support specialist is not available, ACT providers may use staff working on obtaining experience necessary to become a registered peer recovery support specialist to meet this requirement. Only time provided by a registered peer recovery specialist, however, may be included in the time requirements to bill the daily per diem.
    - ISP goals related to peer recovery support services should be based on the individual's identified recovery needs and achieving maximum independence and autonomy in the community.
    - The peer recovery specialist shall act as an advocate for the individual, encouraging the individual to take a proactive role in developing and updating goals and objectives in the recovery planning.
- **Care Coordination:**
    - Providers must follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV).
    - In circumstances where a team discharges an individual from ACT to another behavioral health service provider (including another ACT provider) within the team's service area or county, the ACT team should continue to monitor the transition for 31 days to assure that if an individual does not transition with success to these new services, they are able to voluntarily return to the ACT service. During this 31- day period, the ACT Team shall maintain contact with the new provider to monitor the transition in support of that provider's role in the individual's continued recovery and evolving goals.
- For individuals with a co-occurring substance use diagnosis, the ACT team will provide individual and group therapy for dual disorders treatment based on the principles of Integrated Dual Disorder Treatment and aligned with the individual's readiness/stage of change. In addition, the ACT team will provide active substance use counseling and relapse prevention, as well as substance use education
- ACT teams must offer and have the capacity to provide all of the covered service components identified in the "service description" section of this manual to address the treatment needs identified in the initial comprehensive needs assessment.

        - If the individual consistently deviates from the required services in the ISP, the provider should work with the Managed Care Organization (MCO) or the fee for service (FFS) contractor to reassess for another level of care or model to better meet the individual's needs.
- Special Notes:
    - Medicaid
        - This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.
        - Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.
        - The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.
        - Service authorization requests must be accompanied by sufficient clinical records to support the request. Clinical records must be signed and dated by the requesting provider within 60 days of the date of service requested.

References:

Commonwealth of Virginia. Department of Medical Assistance Services. Provider Manual Title: Mental Health Services Revision Date: 1.16.2026. Appendix E: Intensive Community Based Support. Retrieved 2.17.2026. https://vamedicaid.dmas.virginia.gov/sites/default/files/2025-01/MHS%20-%20Appendix%20E%20%28updated%201.16.25%29_Final.pdf

Keywords:

SHP Sensory – Weighted Vest, SHP Behavioral Health 27, deep-pressure sensory input, Weighted vest, Bear Hug vest, Weighted Compression Vest, Weighted Sensory Vests, Wonder Vests