Humana | Healthy Horizons™ in Ohio

Department: Utilization Management	**Policy and Procedure No:** MCD-OH-CLI-H1368	
Policy and Procedure Title: Assertive Community Treatment (ACT) Medical Necessity		
Process Cycle: Annually	**Responsible Departments:** Clinical	
Approved By: Mark Rastetter MD	**Effective Date:** 2/1/2023	**Revised:**

POLICY AND PROCEDURE:

Policy:
Humana Healthy Horizons™ of Ohio will use established criteria guidelines to make medical necessity decisions on case-by-case basis, based on the information provided on the member's health status.

Procedure:
For assertive community treatment (ACT) services, Humana Healthy Horizons in Ohio uses OAC Rule 5160.27-04

(A) For the purposes of medicaid reimbursement, 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. The ACT model utilizes a multidisciplinary team of practitioners to deliver services to eligible individuals.
(B) For the purposes of this rule, collateral contact occurs when the practitioner contacts individuals who play a significant role in a medicaid recipients life. The information gained from the collateral contact can provide insight into treatment or the basic psychoeducation provided to that collateral contact can assist with the treatment of the medicaid recipient.
(C) The ACT team is the sole provider to ACT recipients of outpatient behavioral health services, including level one outpatient services as defined by the American society of addiction medicine.
(D) ACT services include but are not limited to the following:

(1) Psychiatry and primary care as related to the mental health or substance use disorder diagnoses;
(2) Service coordination;
(3) Crisis assessment and intervention;
(4) Symptom assessment and management;
(5) Community based rehabilitative services;
(6) Education, support, and consultation to families, legal custodians, and significant others who are part of the recipient's support network.

(E) The desired outcomes of ACT intervention for medicaid recipients include but are not limited to:

(1) Achieving and maintaining a stable life in a community based setting;
(2) Reducing the need for inpatient hospital admission and emergency department visits;
(3) Improving mental and physical health status, and improving life satisfaction.

(F) A medicaid recipient may receive ACT services when determined by the ODM designated entity to have met all of the following:

(1) The recipient has a diagnosis of schizophrenia, bipolar, or major depressive disorder with psychosis, in accordance with the ICD-10 diagnosis code group list found at https://bh.medicaid.ohio.gov/manuals;

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(2) The recipient has a supplemental security income or social security disability insurance determination or has a score of two or greater on at least one of the items in the "mental health needs" or "risk behaviors" sections or a score of three on at least one of the items in the "life domain function" section of the adult needs and strengths assessment (ANSA) administered by an individual with a bachelor's degree or higher and with training in the administration of the assessment; and

(3) The recipient has one or more of the following:

(a) Two or more admissions to a psychiatric inpatient hospital setting during the past twelve months; or

(b) Two or more occasions of utilizing psychiatric emergency services during the past twelve months; or

(c) Significant difficulty meeting basic survival needs within the last twenty-four months; or

(d) History within the past two years of criminal justice involvement including but not limited to arrest, incarceration, or probation; and

(4) The recipient experiences one or more of the following:

(a) Persistent or recurrent severe psychiatric symptoms; or

(b) Coexisting substance use disorder of more than six month in duration; or

(c) 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; or

(d) At risk of psychiatric hospitalization, institutional or supervised residential placement if more intensive services are not available; or

(e) Has been unsuccessful in using traditional office-based outpatient services; and

(5) The recipient is eighteen years of age or older at the time of ACT enrollment.

(G) Prior authorization of ACT services.

(1) The provider must submit a request for prior authorization and receive approval from the ODM designated entity before ACT services can be rendered. The request for prior authorization must be accompanied by the appropriate documentation which includes, but is not limited to, the ANSA results or the documentation that supports the social security determination. The maximum amount of ACT service which may be prior authorized at any one time is twelve months.

(2) At the conclusion of the previous ACT service period, the provider agency may request additional ACT service to be prior authorized by the ODM designated entity.

(3) The provider may begin submitting claims for Medicaid reimbursement of ACT services for dates of service within the subsequent calendar month following the date on which prior authorization is approved by the ODM designated entity

(H) Disenrollment of a recipient from ACT. Upon planned or unplanned disenrollment of an ACT recipient, the ACT team shall document the circumstances regarding disenrollment in the recipient's medical record.

(1) A planned disenrollment from ACT occurs when a recipient, or recipient's guardian and ACT team members mutually agree to the termination of ACT services and

transition of the recipient to a different care setting, provider, or benefit package. A planned disenrollment is appropriate when:

(a) The recipient has successfully reached established goals for disenrollment and the recipient and/or their guardian and ACT team members agree to the discharge from ACT; or

(b) The recipient moves outside the geographic area of the ACT team's responsibility. In such cases, the ACT team shall arrange to transfer mental health and substance use disorder service responsibility to another ACT program or other provider wherever the recipient is moving. The ACT team shall maintain contact with the recipient until the transfer is complete; or

(c) The recipient or their guardian requests a disenrollment; or

(d) The recipient is determined by the ODM designated entity to no longer meet the eligibility or medical necessity criteria for ACT.

(2) As part of a planned disenrollment, the ACT team shall document that the recipient has actively participated in disenrollment activities by documenting in the recipient's medical record the following information:

(a) The reason(s) for the recipients disenrollment as stated by both the recipient and the ACT team;

(b) The recipient's progress toward the goals set forth in the treatment plan;

(c) Documentation that the recipient's behavioral health care is being linked and transfered to a provider other than the ACT team;

(d) The signature of the recipient or their guardian, the ACT team leader, and the psychiatric prescriber.

(3) A recipients disenrollment from ACT may be unplanned and due to circumstances facilitated by:

(a) The inability of the ACT team to locate the recipient for more than forty-five days; or

(b) The recipients incarceration, hospitalization or admission to a residential substance use disorder treatment facility. In these circumstances, the primary responsibility for the recipients health care is transferred to the aforementioned setting.

(i) The ACT team is expected to maintain contact with the recipient to assist with transition between settings if the recipient is likely to be discharged and resume service from the ACT team within two months.

(ii) If the recipients stay is predicted to be longer than two months, the recipient shall be disenrolled from the ACT team. (iii) The recipient may be re-enrolled with the ACT team when discharged from the incarcerated, inpatient or residential setting. Any re-enrollment shall follow the eligibility determination criteria described in paragraph (F) of this rule.

(4) Except for services found in paragraph (O) of this rule, a recipient may not obtain behavioral health services from a provider other than the ACT team unless the recipient is disenrolled from ACT services.

(5) The provider must inform the ODM designated entity of disenrollment within three business days of the discharge date. The ODM designated entity shall deactivate the authorization for the ACT service. Failure to timely dis-enroll the recipient from ACT may result in claim denial for other mental health or substance use disorder services.

(I) A provider furnishing ACT services must meet both of the following criteria:

(1) Meets the eligibility requirements found in paragraph (A)(1) or (A)(2) of rule 5160-27-01 of the Administrative Code; and

(2) Employs one or more teams of mental health and substance use disorder practitioners who comprise the ACT treatment team.

(J) Each team must meet the following criteria:

(1) Completed a fidelity review within the previous twelve months by an independent validation entity recognized by ODM. In year one of an ACT teams participation with Ohio medicaid the team must participate in a fidelity review based on the dartmouth assertive community treatment scale (DACTS) and performed by an independent validation entity recognized by ODM. The DACTS fidelity scale and protocol can be found at www.medicaid.ohio.gov.

(a) Fidelity reviews of ACT teams must be repeated every twelve months from the report date of the previous fidelity review.

(b) An ACT team must have documented evidence of compliance to the requirements stated in paragraph (J) of this rule prior to submitting any prior authorization requests for recipients of ACT services.

(2) Each team shall have a designated full-time team leader who may serve in that capacity with only one team.

(a) An ACT team leader shall have a national provider identification number and be actively enrolled as an Ohio medicaid provider.

(b) A team leader shall have psychiatric training and shall hold one of the following valid licenses from the appropriate Ohio 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.

(c) 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 in paragraph (A)(5) of rule 5160-27-01 of the Administrative Code must receive approval from ODM before the ACT team to which they are assigned can begin billing Ohio medicaid.

(3) ACT teams that employ peer recovery supporters must ensure that they meet the criteria and requirements for the peer recovery support services set forth in rule 5160-43-09 of the Administrative Code.

(4) ACT teams must have a caseload no greater than one hundred and twenty and must maintain an average caseload ratio of one practitioner for every ten ACT recipients. Upon request from the ODM, the ACT team must provide to the ODM or its designated entity the ACT team caseload size and composition of medicaid and non-medicaid enrollees.

(K) ODM reserves the right to suspend or terminate the payment of ACT services and to require subsequent review of an ACT team's fidelity performance if ODM has reason to believe that the ACT team's fidelity to the DACTS model described in paragraph (J)(1) of this rule may be in question. ODM may, at its discretion, suspend payment of ACT medicaid claims from the provider agency employing the ACT team until such time as ODM receives documentation from its independent validation entity that the team does meet the fidelity criteria described in paragraph (J)(1) of this rule.

(L) A provider employing an ACT team may bill up to four ACT units per month per recipient when all clinical and billing requirements for each unit are met. The billing of ACT units are subject to the following limits per provider category, per recipient, per month:

(1) Not more than one unit may be billed per medicaid recipient per month for services rendered by the ACT team medical prescriber including physician, clinical nurse specialist, certified nurse practitioner, or physician assistant operating within their respective scopes of practice.

(2) Not more than one unit per medicaid recipient per month may be billed for services rendered by any one of the following ACT team members: psychologist, licensed independent social worker, licensed social worker, licensed clinical social worker, licensed professional counselor, licensed professional clinical counselor, licensed independent clinical counselor, licensed independent marriage and family therapist, licensed marriage and family therapist, licensed practical nurse, registered nurse, licensed independent chemical dependency counselor, licensed chemical dependency counselor II or licensed chemical dependency counselor III. (3) Not more than two units per medicaid recipient per month may be billed by an ACT team member not listed in paragraph (L)(1) or (L)(2) of this rule. This unit category includes: psychology assistant, psychology intern, psychology trainee, social worker assistant, social worker trainee, marriage and family therapist trainee, counselor trainee, chemical dependency counselor assistant, qualified mental health specialist (QMHS), including QMHS with three or more years of experience, and peer recovery supporter.

(M) The medicaid payment rates for ACT are stated in the appendix to rule 5160-27-03 of the Administrative Code. Payment for services provided by authorized ACT teams is only available for dates of services on or after January 1, 2018.

(N) ACT teams shall maintain regular contact and deliver all medically necessary outpatient mental health and substance use disorder services and supports to ACT recipients enrolled with their team.

(O) Services rendered by the ACT team medical prescriber, including physician, clinical nurse specialist, certified nurse practitioner, or physician assistant, are billable when rendered to an

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ACT recipient or via a case specific consultation with another member of the ACT team regarding the medical aspects of the ACT recipient's treatment plan. The ACT team medical prescriber must have at least one contact with each ACT recipient every three months.
(P) When a recipient is enrolled on an ACT team, no other medicaid community behavioral health services, as defined in Chapter 5160-27 of the Administrative Code, are eligible for reimbursement except:

(1) Supported employment as identified on a recipient's specialized recovery services program treatment plan if applicable, as described in rule 5160-43-01 of the Administrative Code.
(2) Substance use disorder services that are not considered part of the benefit package encompassed under level one of the american society of addiction medicine (ASAM) as defined in rule 5160-27-09 of the Administrative Code. Prior authorization from the ODM designated entity is required.
(3) Crisis services furnished by a provider other than the billing provider agency employing the ACT team.

(Q) Documentation requirements for ACT.

(1) Documentation in the recipient's medical record of the services provided by the ACT team must meet the requirements stated in this paragraph as well as those stated in rules 5160-1-27 and 5160-8- 05 of the Administrative Code.
(2) The ACT team must develop a specific treatment plan for each enrolled recipient. The treatment plan must, at a minimum, meet the requirements of rule 5160-8-05 of the Administrative Code plus the following additional requirements:

(a) The treatment plan shall be individualized based on the recipient's needs, strengths, and preferences and shall set measurable long-term and short-term goals and specify approaches and interventions necessary for the recipient to achieve the recipient goals. The treatment plan shall also identify who will carry out the approaches and interventions.
(b) The treatment plan shall address, at a minimum, the following key areas:
(i) Psychiatric illness or symptom reduction.
(ii) Stable, safe, and affordable housing.
(iii) Activities of daily living.
(iv) Daily structure and activities, including employment if appropriate.
(v) Family and social relationships.
(c) The treatment plan shall be reviewed and revised by a member of the ACT team with the recipient whenever a change is needed in the recipient's course of treatment or at least every six months. In conjunction with a treatment plan review, the ACT team member shall prepare a summary of the recipient's progress, goal attainment, effectiveness of the intervention and recipient's satisfaction with the ACT team interventions since enactment of the previous treatment plan.
(d) The treatment plan, and all subsequent revisions of it, shall be reviewed and signed by the recipient and the ACT team practitioner.

(R) The following activities performed by members of the ACT team are not eligible for reimbursement:

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(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) Child care 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 directly 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) Contacts that are not medically necessary.
(11) Any service outside the responsibility of the ACT team.
(12) Vocational training and supported employment services, unless the recipient is enrolled in the specialized recovery services program as described in rule 5160-43-01 of the Administrative Code.
(13) Crisis intervention provided by the provider agency employing the ACT team.

CPT® Code(s)	Description
	No code found
CPT® Category III Code(s)	**Description**
	No code found
HCPCS Code(s)	**Description**
H0040	Assertive community treatment program, per diem

1) The Plan covers all benefits and services required in OAC chapter 5160 in the amount, duration, and scope for the same services furnished to members under the fee-for-service (FFS) Medicaid.
2) When applying coverage policies and medical necessity criteria, the Plan will consider individual member needs and an assessment of the local delivery system.
3) The Plan uses the following hierarchy of guidelines to review for medical necessity:
    a) Federal or state regulation, including medical criteria published in the Ohio Administrative Code, Chapter 5160.

b) Nationally accepted evidence based clinical guidelines: MCG (formerly Milliman Care Guidelines), American Society of Addiction Medicine (ASAM) Level of Care Adolescent Guidelines and American Society of Addiction Medicine (ASAM) Patient Placement Criteria (ASAM Admission Guidelines)
c) Humana Healthy Horizons in Ohio clinical policies
d) In the case of no guidance from above, additional information that the clinical reviewer will consider, when available, includes:
    i. Clinical practice guidelines and reports from peer reviewed medical literature, from which a higher level of evidence and study quality is more strongly considered in determinations;
    ii. Professional standards of safety and effectiveness recognized in the US for diagnosis, care, or treatment;
    iii. Medical association publications
    iv. Government-funded or independent entities that assess and report on clinical care
    v. decisions and technology such as Agency for Healthcare Research and Quality (AHRQ), Hayes Technology Assessment, Up-To-Date, Cochrane Reviews, National Institute for Health and Care Excellence (NICE), etc.;
    vi. Published expert opinions;
    vii. Opinion of health professionals in the area of specialty involved;
    viii. Opinion of attending provider
e) Dental: DentaQuest coverage guidelines and policies
Dental Coverage - Humana Healthy Horizons in Ohio | Humana
f) Vision: EyeMed coverage guidelines and policies
Vision Care - Humana Healthy Horizons - Ohio Medicaid | Humana

Only practitioners with the appropriate clinical expertise can make the decision to deny or reduce the amount, duration or scope of the services being requested.

Humana Healthy Horizons™ in Ohio requires prior authorization on all “Miscellaneous”, “Unlisted”, “Not Otherwise Specified” codes. Medical necessity documentation and rationale must be submitted with the prior authorization request. The medical director adheres to the above process to align criteria based on the information provided on the member’s health status.

Members may request a copy of the medical necessity criteria by calling member services at 877-856-5702 (TTY:711), Monday-Friday, from 7 a.m. to 8 p.m.

Providers may submit a request for medical necessity request by calling 877-856-5707 (TTY:711), Monday – Friday, from 7 a.m. to 8 p.m. EST or emailing the request to OHMCDUM@humana.com.

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RESOURCES:

- Ohio Administrative Code 5160-1-01 Medicaid medical necessity: definitions and principles. Retrieved October 28, 2022, from https://codes.ohio.gov/ohio-administrative-code/5160
- Ohio Administrative Code 5160-27-04 Mental Health assertive community treatment service. Retrieved December 20, 2022 https://codes.ohio.gov/assets/laws/administrative-code/authenticated/5160/0/27/5160-27-04_20210101.pdf

CONTRACT LANGUAGE:

5. Coverage Requirements

a. Medical Necessity Criteria

i. Pursuant to OAC rule 5160-26-03, the MCO's coverage requirements and decisions must be based on the coverage and medical necessity criteria published in OAC Chapter 5160 and practice guidelines as specified in OAC rule 5160-26-05.1.

ii. The MCO must have objective, written criteria based on sound clinical evidence to make medical necessity and utilization decisions. The MCO must involve appropriate providers in the development, adoption, and review of medical necessity criteria. The MCO's written criteria must meet NCQA standards and must specify procedures for appropriately applying the criteria.

iii. The MCO must use ODM-developed medical necessity criteria where it exists. In the absence of ODM-developed medical necessity criteria, the MCO must use clinically-accepted, evidence-informed medical necessity criteria (e.g., InterQual®, MCG®, and ASAM) as approved by ODM.

iv. In the absence of ODM-developed medical necessity criteria or ODM-approved, clinically-accepted, evidence-informed medical necessity criteria, the MCO's adaptation or development of medical necessity criteria must be based upon evaluated, peer reviewed medical literature published in the United States.

1. Peer reviewed medical literature must include investigations that have been reproduced by non-affiliated authoritative sources.
2. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale that is based upon well-designed research and endorsements by national medical bodies or panels regarding scientific efficacy and rationale.

v. When applying coverage policies and medical necessity criteria, the MCO must consider individual member needs and an assessment of the local delivery system.

DEFINITIONS:

Adverse Benefit Determination – As defined in OAC rule 5160-26-08.4, a Managed Care Organization's (MCO's):

a. Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

b. Reduction, suspension, or termination of services prior to the member receiving the services previously authorized by the MCO;
c. Denial, in whole or part, of payment for a service (a denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" is not an adverse benefit determination);
d. Failure to provide services in a timely manner as specified in OAC rule 5160-26-03.1;
e. Failure to act within the resolution timeframes specified in this rule; or

f. Denial of a member's request to dispute a financial liability, including cost sharing, co-payments, premiums, deductibles, coinsurance, and other member financial liabilities, if applicable.

American Society of Addiction Medicine (ASAM) – a professional medical society representing over 7,000 physicians, clinicians, and associated professionals in the field of addiction medicine. ASAM produces a comprehensive set of standards for placement, continued stay, transfer or discharge of patients with addition and co-occurring conditions used by clinical staff to determine whether to refer a service request for physician review based upon the clinical information submitted by the requestor.

MCG® – Formerly known as Milliman Care Guidelines, are nationally recognized guidelines used by clinical staff to determine whether to refer a service request for physician review based upon the clinical information submitted by the requestor.

Medically Necessary or Medical Necessity – Has the same meaning as OAC rule 5160-1-01:

a. Medical necessity for individuals covered by early and periodic screening, diagnosis, and treatment (EPSDT) is defined as procedures, items, or services that prevent, diagnose, evaluate, correct, ameliorate, or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability.
b. Medical necessity for individuals not covered by EPSDT is defined as procedures, items, or services that prevent, diagnose, evaluate, or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability, and without which the person can be expected to suffer prolonged, increased, or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort.
c. Conditions of medical necessity are met if all the following apply:
    i. It meets generally accepted standards of medical practice;
    ii. It clinically appropriate in its type, frequency, extent, duration, and delivery setting;
    iii. It is appropriate to the adverse health condition for which it is provided and is expected to produce the desired outcome;
    iv. It is the lowest cost alternative that effectively addresses and treats the

medical problem;

v. Provides unique, essential, and appropriate information if it is used for diagnostic purposes; and
vi. It is not provided primarily for the economic benefit of the provider nor for the convenience of the provider or anyone else other than the recipient.

d. The fact that a physician, dentist, or other licensed practitioner renders, prescribes, orders, certifies, recommends, approves, or submits a claim for a procedure, item, or service does not, in and of itself, make the procedure, item, or service medically necessary and does not guarantee payment for it.
e. The definition and conditions of medical necessity articulated in this rule apply throughout the entire Medicaid program. More specific criteria regarding the conditions of medical necessity for particular categories of service may be set forth within ODM coverage policies or rules.

VERSION CONTROL

Version Review Approval History				
Department:	**Purpose of Review**	**Reviewed and Approved By:**	**Date:**	**Additional Comments:**
Clinical	Policy Development		12/20/2022	
Clinical		Mark Rastetter, MD	12/20/2022	

DISCLAIMER:

Humana follows all federal and state laws and regulations. Where more than one state is impacted by an issue, to allow for consistency, Humana will follow the most stringent requirement.

This document is intended as a guideline. Situations may arise in which professional judgment may necessitate actions that differ from the guideline. Circumstances that justify the variation from the guideline should be noted and submitted to the appropriate business area for review and documentation. This (policy/procedure) is subject to change or termination by Humana at any time. Humana has full and final discretionary authority for its interpretation and application. This (policy/procedure) supersedes all other policies, requirements, procedures or information conflicting with it. If viewing a printed version of this document, please refer to the electronic copy maintained by CMU to ensure no modifications have been made.

NON-COMPLIANCE:

Failing to comply with any part of Humana's policies, procedures, and guidelines may result in disciplinary actions up to and including termination of employment, services or relationship with Humana. In addition, state and/or federal agencies may take action in accordance with applicable laws, rules and regulations.

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Any unlawful act involving Humana systems or information may result in Humana turning over all evidence of unlawful activity to appropriate authorities. Information on handling sanctions related to non-compliance with this policy may be found in the Expectations for Performance, and Critical Offenses policies, both of which may be found in the Associate Support Center via Humana's secure intranet of Hi! (Workday & Apps/Associate Support Center).