

## Assertive Community Treatment (ACT) Billing Guidance

### Overview:

Medicaid billable ACT will be implemented effective 7/1/2016 for dually certified (mental health and SUD) behavioral health provider organizations who have moved to the new code set. Only agencies who have been reviewed and found to have a BASIC level of fidelity to the DACT or the TMACT Models (see more below) may bill Ohio Medicaid for ACT.

Each ACT team may bill a maximum of 4 per diem rates per month.<sup>1</sup> ACT per diems may only be billed for dates of service when one or more members of the ACT team has performed a face-to-face service with the individual or a family member. Only one per diem may be billed per category of practitioner type, per individual, per day. A maximum of two practitioners - representing different categories of practitioner type - may bill on the same day (i.e. a maximum of two per diems can be billed on a given day.) All other contacts, meetings, travel time, etc., are considered indirect costs and are accounted for in the development of the per diem rate.

Medicaid rates have been set according to the caseload size of each team:

- Small ACT teams serve, on average 47 individuals with no more than 50 individuals.
  - Medium ACT teams serve 51-75 individuals (71 on average).
  - Large ACT teams serve 76-100 individuals (95 on average).
- For an ACT team per diem to be billable, a 15-minute or longer face-to-face contact must meet the requirements below. A 15-minute contact is defined as lasting at least 8 minutes. Group contacts alone are not billable and do not qualify as a face-to-face contact for billing an ACT per diem rate.
  - Practitioners may not bill for activities reimbursed via the ACT per diem and also bill for those activities outside the ACT per diem for the same enrollee.
  - When ACT is billed no other mental health or SUD services should be billed with the following exceptions: Specialized Recovery Services Program (SRSP) Recovery management and Specialized Recovery Services Program (SRSP) supported employment as out lined below.
  - SUD treatment in addition to ACT is only permitted with prior authorization. SUD targeted case management, psychiatrist services, other licensed practitioner services, and rehabilitation services other than ACT are not permitted.
  - The psychiatric prescriber shall be physically located at the home clinic of the ACT team in order to provide office-based services and services in the community when indicated.

### Supported Employment:

Supported employment provided by an ACT team requires prior authorization and may be billed only when Supported Employment goals and activities are specifically outlined on the individual's Recovery Plan. The team may bill up to one extra bachelor's level unit per month (i.e. a 5<sup>th</sup> per diem) for the team Vocational Specialist when vocational activities were conducted consistent with the TMACT fidelity model. Documentation must be maintained regarding the vocational activities performed and the goals/activities completed for each individual in the individual's medical record.

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<sup>1</sup> The only exception is that a 5<sup>th</sup> per diem may be billed to account for vocational services provided to ACT enrollees for whom supported employment is specifically outlined in the recovery plan. (See more details above regarding supported employment.)

## ACT Billing Rates, Codes & Modifiers by Team Member

ACT intervention will be billed to Ohio Medicaid using the HCPCS code H0040 followed by a required modifier indicating the qualifications of the practitioner who rendered the intervention. Medicaid rates have been set based on practitioner qualifications and the caseload size. The categories below specify the practitioner types, the representative modifier for each and the rates for each based on caseload size.

### **Physician:**

H0040 AM

- Small: \$662.60
- Medium: \$615.54
- Large: \$585.22

### **Nurse Practitioner:**

H0040 HP

- Small: \$383.75
- Medium: \$352.75
- Large: \$333.20

### **Master's Level (includes Registered Nurses):**

H0040 HO

- Small: \$282.80
- Medium: \$251.91
- Large: \$234.98

### **Bachelor's Level:**

H0040 HN

- Small: \$221.41
- Medium: \$199.70
- Large: \$186.48

### **Peer Level:**

H0040 HM

- Small: \$178.50
- Medium: \$159.24
- Large: \$147.70

Practitioners on the ACT teams are subject to the following billing limits per category, per month, per individual, not to exceed a total of 4 per diems (as defined above) per individual in total from any combination of practitioners. (Note: the billing must be based on actual services provided to the individual. *Medically necessary care consistent with the fidelity model should be delivered even if beyond the minimum number of units permitted to be billed under this reimbursement strategy.*)

- Category 1: Physicians and APRNs may not bill more than one (1) per diem for a individual per month in total.
- Category 2: Any combination of masters level clinicians including Psychologist, team leader, LISW, LPCC, LIMFT, LICDC, LPC, LSW, LMFT, master's level behavioral health other. RNs and LPNs are also in Category 2. All of these practitioners may only bill 1 per diem for an individual in a monthly total. Ideally, this visit will not be in a clinic setting.
- Category 3: All other practitioners on the ACT teams may bill up to two (2) per diems for an individual in a monthly total. Ideally, these visits will not be in a clinic setting.

### ***Non-Fidelity ACT Rate Level***

A team that does not meet an ACT basic level fidelity rating (see definitions below) may not bill the rates listed above. Instead these teams may only bill individual services listed in either the old or new code set for Ohio Medicaid behavioral health.

### ***Basic ACT Team Fidelity Level***

The State of Ohio will be implementing the TMACT fidelity model beginning July 1, 2016. However, ACT teams operational prior to July 1, 2016 who meet basic fidelity on the DACT scale will be allowed to bill Ohio Medicaid for team based care to ACT enrollees. "Grandfathered" ACT teams will have a total of 18 months to transition to a BASIC fidelity level using the TMACT model. Within the first 6 months after they begin billing Medicaid, grandfathered teams must undergo a TMACT review and then meet BASIC fidelity ratings within the next 12 months.

Both grandfathered DACT teams and TMACT teams meeting minimum fidelity scores may bill for up to 4 per diems, per month, per individual when all other requirements for a visit are met (i.e., a face-to-face service with the individual or family member). Consistent with the fidelity model, medically necessary care should be delivered even if it is beyond the minimum number of units billable under this reimbursement strategy.

Teams utilizing the DACT fidelity model must meet an overall average fidelity rating of 3.0. Teams utilizing the TMACT fidelity model must achieve the following minimum fidelity rating scores on the following subscales:

- A minimum average of 3.0 across the following items from the OS subscale must be achieved:
  - OS1 — Low ratio of individuals to staff.
  - OS5 — Program size.
  - OS6 — Priority service population.
  - OS10 — Retention rate.
- A minimum average rating of 3.0 on the CT subscale.
- A minimum rating of 3.0 on CP subscale CP1 — community-based services item.

At any time during the 12-month period of basic fidelity level certification, the Ohio Department of Medicaid (ODM) can request additional information to assess any questions that may arise regarding a TMACT fidelity metric. At the time of request, all subsequent billing will be pended subject to verification of the identified TMACT fidelity metric. If the additional review reveals that the fidelity score for any identified metric falls below the standards for OS, CT, and CP1 listed above, the team will have 90 days to demonstrate capacity at a level above the required minimums for each identified metric. If such capacity is not demonstrated to the satisfaction of ODM, billing will revert to the non-fidelity ACT level for all pended and future services until at least basic fidelity level is achieved on those identified metrics.

The following activities may not be billed as part of the ACT per diem rate, and if billed, will be recouped if discovered in an audit:

- Contacts that are not medically necessary.
- Time spent doing, attending, or participating in recreational activities.
- Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide, or an academic tutor.
- Habilitative services for the individual (adult) to acquire, retain, and improve the self-help, socialization, and adaptive skills necessary to reside successfully in community settings.

- Child Care services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
- Respite care.
- Transportation for the individual or family. Services provided in the car are considered Transportation and time may not be billed for ACT.
- Covered services that have not been rendered.
- Services rendered that are not in accordance with an approved authorization.
- Services not identified on the individual's authorized ACT participant-directed service plan.
- Services provided without prior authorization by the department or its designee (e.g. a 5<sup>th</sup> per diem if Supported Employment is listed in the individual's treatment plan)
- Services provided before the department or its designee (including a Managed Care Plan) has approved authorization.
- Services not in compliance with the ACT service manual and not in compliance with fidelity standards.
- Services provided to children, spouse, parents, or siblings of the eligible individual under treatment or others in the eligible individual's life to address problems not directly related to the eligible individual's issues and not listed on the eligible individual's ACT participant-directed service plan.
- Services provided that are not within the provider's scope of practice.
- Any art, movement, dance, or drama therapies.
- Anything not included in the approved ACT service description.
- Changes made to ACT that do not follow the requirements outlined in the provider contract, service manual, or ACT fidelity standards.
- Any intervention or contact not documented or consistent with the approved treatment/recovery plan goals, objectives, and approved services will not be reimbursed.
- Employment of the individual. ACT includes non-job specific vocational training, employment assessments, and ongoing support to maintain employment. ACT may also pay for the 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 that enable the individual to function in the workplace.