

## ACT Reimbursement

(updated 9/17/13)

### **Overview**

Assertive Community Treatment teams are reimbursed by MO HealthNet or by Department of Mental Health state funding. Most of the cost of the ACT team will be reimbursed through a daily ACT team rate. This procedure code is billable on each day that an enrolled ACT client receives a direct (face-to-face) service from any team member other than the physician or advance practice nurse. Services include both individual and group services. Group services must be for an enrolled ACT consumer in a group facilitated by an ACT team staff. Medication Management and Physician Consultation are carved out of the ACT team rate and are billed separately. There are separate procedure codes set up for both the physician/psychiatrist and the advance practice nurse (if used). In addition, certain interventions by the vocational specialist that are not Medicaid reimbursable are also billed separately to the Department, regardless of the Medicaid eligibility of the recipient.

### **ACT billing process**

All ACT service claims are submitted to the Department of Mental Health using CIMOR.

### **ACT Client Enrollment in CIMOR**

All ACT clients must be registered and enrolled in CIMOR and assigned to the 'CPS Assertive Community Treatment' program.

### **Limitations: Billing ACT and other CPR services**

ACT clients will generally not have current services on the CPR menu billed during the time that they are enrolled in ACT. The current Intake and Annual Evaluation procedure codes (H0031, H003152) may not be billed while the client is enrolled in ACT. Evaluation, assessment, and treatment planning activities by ACT team members will be billed using the ACT team rate. As ACT team members assess clients according to the protocol outlined in the NAMI-PACT Manual, those contacts qualify for billing the ACT team rate. However, we recognize that as some clients transition out of ACT services into traditional CPR, they may need to concurrently receive services such as community support and psychosocial rehabilitation from the regular CPR program during a brief transition period. In addition, the Department will allow ACT clients to received co-occurring group substance abuse counseling outside of the ACT program.

### **Services, Rates, Procedure codes**

There are seven procedures codes set up for reimbursement of ACT teams. All are payable to both the Department and MO HealthNet, except for ACT implementation and vocational services, which are only paid by the Department.

#### **1. ACT team rate**

Procedure code is H0040. Provider pay rate is \$108.15.

This procedure is billable on each day that an enrolled ACT client receives a direct (face-to-face) service from any team member (individual or group) other than the physician or advance practice nurse. The only exception is regarding certain direct vocational interventions delivered by the vocational specialist (see more below). The cost of the physician/APN participating in the daily team meetings and other non-medication management activities are built into the rate. The procedure may only be billed once per day per client; if a client receives multiple direct contacts in a day from non-medical team members, the procedure code is only billed once.

MO HealthNet is billed the daily ACT team rate for clients with MO HealthNet eligibility, and the Department is billed for clients who do not have MO HealthNet eligibility.

Assessments: assessment activities by team members qualify for billing the ACT team rate. Providers may bill the ACT team rate on any day that a team member works on the functional assessment activities described in the NAMI-PACT manual.

Documentation: All direct services which result in the billing of the ACT team rate must be documented in the client case record according to current DMH and MO HealthNet requirements that are described in the Code of State Regulations for Core Rules and Mental Health programs. Significant collateral/indirect contacts, including contacts with natural supports, should also be documented with a progress note in the client case record describing the contact.

## **2. Medication Services-ACT**

~~Procedure code is 90862HK. Provider pay rate is \$49.38 per quarter hour unit.~~

Update: Procedure code 90862 is no longer available. Please refer to the CPT replacement code mapping on the following web page: <http://dmh.mo.gov/mentalillness/provider/codes.htm>

When the ACT team physician delivers medication management to the client, the service is billed separately from the ACT team rate, using the appropriate evaluation and management procedure code.

Documentation: All medication management services must be documented in the client case record according to current DMH and MO HealthNet requirements that are described in the Code of State Regulations for Core Rules and Mental Health programs.

## **3. Medication Services (APN)-ACT**

~~Procedure code is 9086252HK. Provider pay rate is \$30.84 per quarter hour unit.~~

Update: Procedure code 90862 is no longer available. Please refer to the CPT replacement code mapping on the following web page: <http://dmh.mo.gov/mentalillness/provider/codes.htm>

When the ACT team APN (if used) delivers medication management to the client, the service is billed separately from the ACT team rate, using the appropriate evaluation and management procedure code.

Documentation: All medication management services must be documented in the client case record according to current DMH and MO HealthNet requirements that are described in the Code of State Regulations for Core Rules and Mental Health programs.

#### **4. Physician Consultation-ACT**

Procedure code is 99241HK. Provider pay rate is \$49.38 per quarter hour unit

When the ACT team physician provides a substantial consultation service (meeting the 15 minute unit requirement), the service is billed separately from the ACT team rate, using procedure code 99241HK. Note: This is not billed for the time the physician spends in the daily team meeting reviewing client status with the other team members. Those costs are built into the daily team rate. This procedure code should be used for individual case consultation that occurs outside of the team meeting.

Documentation: All physician consultation services must be documented in the client case record according to current DMH and MO HealthNet requirements that are described in the Code of State Regulations for Core Rules and Mental Health programs.

#### **5. Physician Consultation (APN)-ACT**

Procedure code is 9924152HK. Provider pay rate is \$30.84 per quarter hour unit.

When the ACT team APN (if used) provides a substantial consultation service (meeting the 15 minute unit requirement), the service is billed separately from the ACT team rate, using procedure code 9924152HK. Note: This is not billed for the time the APN spends in the daily team meeting reviewing client status with the other team members. Those costs are built into the daily team rate. This procedure code should be used for individual case consultation that occurs outside of the team meeting.

Documentation: All physician consultation-APN services must be documented in the client case record according to current DMH and MO HealthNet requirements that are described in the Code of State Regulations for Core Rules and Mental Health programs.

#### **6. Vocational Services-ACT**

Most interventions provided by the ACT vocational specialist qualify for billing the ACT team rate. However, as Medicaid does not reimburse for direct vocational activities such as job development and job coaching, some interventions will need to be billed to the Department, even though the client has Medicaid eligibility. Please reference the ACT Vocational Criteria attachment for guidelines on determining which interventions are billable to Medicaid and which should be billed to the Department using service code H2023HK.

#### **7. ACT implementation**

Procedure code is 9603W. Rate is a zero unit rate.

This service is billed on one line for the following types of approved start-up and implementation

costs associated with ACT teams, including:

- One-time equipment start-up costs
- Staff salaries as team members are being hired (prior to the full team being employed)
- Unreimbursed team cost during initial client enrollment
- Client fund accounts
- Training costs approved by the Department

Documentation: The provider must keep documentation sufficient to justify equipment/expense and client fund accounts in a separate file, subject to review during compliance/monitoring visits.

### **Allocation Methodology**

The Department used proposed budgets submitted by applicants for the ACT appropriation funding to establish the ACT team daily rate initially set at \$105.00. The Department took the team size times the case rate times 96 contacts annually to arrive at an initial ACT team allocation. For example, on a team of 70 clients: 70 clients x \$105 x 96 = \$705,600 team allocation. A separate allocation will be created and set aside for medication management, physician consultation, and vocational services (interventions that are carved out of the daily ACT team rate). One-time start-up costs and client fund accounts will be billed separately and amounts must be approved by the Department.

Each program committed to an amount of current allocation to fund their ACT team. This amount was negotiated between the provider and the Department. The Department initially added an amount from the new ACT appropriation sufficient to draw down the allocations at a presumptive 75%/25% Medicaid/Non-Medicaid service unit mix. The Department will monitor the actual mix of Medicaid and non-Medicaid billings, and adjust the amount of the new ACT appropriation necessary to fund the services. Funding for the one-time start-up costs and client fund accounts are paid from the ACT appropriation.

### **Start-Up/Implementation Period**

During an initial start-up period, which we project will vary from 4-6 months for each team (depending on how many current CPR clients are brought over to the ACT team and the rate of admission of new clients, up to team capacity), the Department will insure that programs are reimbursed the full cost of their established ACT team allocation (see Allocation Methodology section above).

Since programs during this start up period will be incurring full team salary costs but will not have enough clients enrolled to generate billable services to draw the allocation down, the Department will reimburse the difference between billable units generated on a client specific basis and one-twelfth of the established team allocation. This will be billed on one line using the 9603W code.

For example, if the established ACT team allocation is \$600,000 (\$50,000 per month), and during the first month of operation the team delivers \$10,000 in direct services to enrolled client, the provider may bill \$40,000 to the 9603W procedure code. Each subsequent month, as the team

works towards enrolling clients up to their specified capacity, the difference between direct client billings and \$50,000 may be billed to 9603W.