Assertive Community Treatment (ACT)/Assertive Community Treatment/Transition Age Youth (ACT/TAY) teams are reimbursed by MO HealthNet or by Department of Mental Health (the Department) state funding. Most of the cost of the ACT/ACT TAY team will be reimbursed through a daily ACT/ACT TAY team rate. This procedure code is billable on each day that an enrolled ACT/ACT TAY client receives a direct intervention in person or by phone from an ACT/ACT TAY team member excluding medication management, consultation and group services by physicians, child psychiatrists, psychiatric residents, psychiatric pharmacists, physician assistants and advance practices nurses (collectively referred to as ACT/ACT TAY team prescribers). The ACT/ACT TAY procedure code may also be billed when an ACT/ACT TAY team member makes direct contact in person or by phone with families, natural supports or other agencies on behalf of the client. Services include both individual and group services. Group services must be for an enrolled ACT/ACT TAY consumer in a group facilitated by an ACT/ACT TAY team staff.

**Note:** For agencies designated as Certified Community Behavioral Health Centers (CCBHCs), billing guidance defaults to requirements for CCBHCs. See bulletin related to clinical implications for ACT/ACT TAY and CCBHCs.

ACT/ACT TAY services are community based interventions provided by a transdisciplinary team responsible for coordinating and providing a comprehensive array of services. The team includes the following team members: team leader, prescriber, nurse, substance use disorder specialist, vocational specialist, peer specialist, community support specialist, therapist, family support specialist and program assistant. Team interventions include but are not limited to: specialized assessment and treatment planning; case management; crisis intervention; assistance in locating and maintaining safe, affordable housing; assistance with finding and maintaining employment and/or education; skills training to support daily living skills, self-care skills and financial management; illness and symptom management; substance use disorder treatment and supports, peer support services; empirically supported psychotherapy; and supporting and facilitating access to necessary medical and social services. A family support specialist provides a support system for the parent/guardian of young adults through age 25.

Prescriber services including Medication Management, Physician Consultation and groups by prescriber are carved out of the daily team rate and are billed separately. There are separate procedure codes for each of these services with modifiers for each prescriber type (Physician, APN, Resident, Physician Assistant, and Psychiatric Pharmacist). In addition, certain interventions by the vocational specialist that are not reimbursable by MO HealthNet 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 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. All ACT TAY clients must be registered and enrolled in CIMOR and assigned to the ‘CPS Youth Assertive Community Treatment’ program.
Limitations: Billing ACT and other CPR services
ACT/ACT TAY clients will generally not have current services on the CPR menu billed during the time that they are enrolled in ACT/ACT TAY. The current Intake and Annual Evaluation procedure codes (H0031, H003152) may not be billed while the client is enrolled in ACT/ACT TAY. Evaluation, assessment, and treatment planning activities by ACT/ACT TAY team members will be billed using the daily team rate. As ACT/ACT TAY team members assess clients according to the protocol outlined in the NAMI-PACT Manual, those contacts qualify for billing the daily team rate. However, we recognize that as some clients transition out of ACT/ACT TAY services into traditional CPR, they may need to concurrently receive services such as community support and psychosocial rehabilitation from the CPR program during a brief transition period.

The cost of the team prescriber participating in the daily team meetings and other non-medication management activities are built into the rate. The ACT ACT/TAY procedure code 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.

ACT/ACT TAY Services
Procedures codes are available for reimbursement of ACT/ACT TAY team services. All are payable to both the Department and MO HealthNet, except for ACT implementation, vocational services and case management by Prescriber, which are only paid by the Department.

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.

1. ACT team rate

Procedure code is H0040 – Assertive Community Treatment
Procedure code is H0040 HA – Assertive Community Treatment Transition Age Youth

Documentation: All direct services which result in the billing of the daily team rate must be documented in the client case record according to current Department and MO HealthNet requirements that are described in the Code of State Regulations for Core Rules and Mental Health programs. Direct contact in person or by phone with families, natural supports or other agencies on behalf of the client will also be documented with a progress note in the client case record describing how the service intervention is related to the identified client under whose name and identification number the billing will be submitted to the Department or MO HealthNet, and how the activity is related to the treatment plan.
2. Prescriber Services

When the ACT/ACT TAY team prescriber delivers medication management to the client, the service is billed separately from the daily team rate, using the appropriate evaluation and management procedure code (see attachment 1).

When the ACT/ACT TAY team prescriber provides a substantial consultation service (meeting the 15 minute unit requirement), the service is billed separately from the daily team rate (see attachment 1).

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.

When the ACT team prescriber provides psychoeducation group services or psychotherapy focused group services, the service is billed separately from the daily team rate (see attachment 1).

Documentation: All medication management, consultation or group services by ACT/ACT TAY prescribers must be documented in the client case record according to current Department and MO HealthNet requirements that are described in the Code of State Regulations for Core Rules and Mental Health programs.

3. Vocational Services-ACT

Most interventions provided by the ACT/ACT TAY vocational/educational specialist qualify for billing the daily 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 (see attachment 2) for guidelines on determining which interventions are billable to Medicaid and which should be billed to the Department.

4. ACT implementation

ACT start up and implementation may be invoiced to the Department of Mental Health. 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.
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/ACT TAY 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 team allocation.

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 amount will be invoiced to the Department.

For example, if the established ACT/ACT TAY 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 invoice $40,000 to the Department. 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 invoiced to the Department.