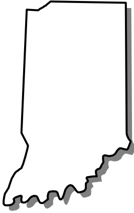

PROVIDER BULLETIN

BT200413 JUNE 18, 2004

To: **All Medicaid Rehabilitation Option Service Providers**

Subject: **Assertive Community Treatment Service Coverage, Standards, and Requirements**

Overview

This bulletin updates Medicaid Rehabilitation Option (MRO) service providers about coverage of assertive community treatment (ACT) service approved as a new Indiana Health Coverage Program (IHCP) covered service with a retroactive effective date. ACT is an intensive mental health service for consumers discharged from a hospital after multiple or extended stays or who are difficult to engage in treatment. ACT services are provided by an interdisciplinary staff team as defined under *440 IAC 5.2-2-3* and must be ordered by a physician.

Consumers receiving this intensive level of community support will experience increased community tenure and decreased frequency or length of hospitalization or crisis services.

Coverage Criteria and Prior Authorization

Prior authorization (PA) is required for ACT services covered by the IHCP. Before admission to an approved ACT team under *440 IAC 5.2-2-3*, an assessment of the patient's current medical status, psychiatric history and status at time of consideration for ACT services, and treatment plan goals must be documented and reviewed by the ACT team psychiatrist.

PA criteria for ACT services are described in *405 IAC 5-21-8(d)*. PA for ACT services must be documented in the individual's medical record. At a minimum, the following are required components of ACT service PA and must be documented in the medical record:

- Medicaid provider identification number of ACT team's Community Mental Health Center (CMHC)
- Patient's level of functioning factor score at the date of most recent assessment and the date of that assessment
- A clinical summary including documentation of any institutionalizations and hospital visits related to the patient's condition in the past two years, documentation supporting the patient's severe limitations with activities of daily living, a current treatment plan, and documentation supporting how the patient met the CMHC requirements for ACT participation as defined in *440 IAC 5.2-2-4*
- Signature of the ACT team psychiatrist

The signature of the ACT team psychiatrist is considered the clinical review required for PA. It is not necessary to submit PA requests to Health Care Excel (HCE). The Division of Mental Health and Addiction (DMHA) will review random samples of ACT PAs for appropriateness and to ensure that required details are captured.

> *Note: The provider is responsible for compiling and maintaining the necessary documentation for PA. ACT services are only reimbursable for persons who meet the criteria described in* 405 IAC 5-21-8 *and for whom the ACT team psychiatrist has documented medical necessity.*

ACT services are intensive and are not time-limited. However, the individual treatment plan and treatment plan goals should be reviewed and updated every 90 days at a minimum. Consumers who no longer need ACT services should be discharged from the ACT team in accordance with ACT team policy.

Service Standards

Development of an individual treatment plan that includes medication administering and monitoring; self medication monitoring; crisis assessment and intervention; symptom assessment, management and individual supportive therapy; substance abuse training and counseling; psychosocial rehabilitation and skill development; personal, social, and interpersonal skill training; and coordination with case management, consultation, and psycho-educational support for individuals and their families provided on behalf of the ACT consumer is required.

Services must be available 24 hours a day, seven days a week with emergency response coverage, including availability of a psychiatrist. Consumers receiving ACT services must not attend traditional partial hospitalization programs.

The ACT team must meet and discuss the services rendered, scheduled services, and progress of ACT consumers on a daily basis during the five-day work week to meet the service standard. ACT teams should have a procedure in place to track daily team meeting attendance and client tracking (for example, cardex system, minutes, and so forth).

Retroactive Coverage Considerations

Coverage of ACT services is effective November 1, 2003. To bill for retroactive coverage, providers must have a DMHA-approved, provisionally certified ACT team or regularly certified ACT team under DMHA policy during the time period beginning November 1, 2003, through May 31, 2004. ACT teams in conditional status may not seek IHCP reimbursement for ACT service. Upon completion of PA documentation, the provider may bill the IHCP for dates of retroactive coverage on or after November 1, 2003. ACT teams must be provisionally certified or regularly certified under *440 IAC 5.2-2* to bill the IHCP for ACT services beginning June 1, 2004.

Billing and Reimbursement

Providers may submit claims for ACT services using the CMS-1500 paper claim or HIPAA-compliant electronic 837P claim. Providers may bill the IHCP for one unit of ACT service daily per approved consumer, provided that the ACT team meets the ACT service standard. ACT services must be billed using Healthcare Common Procedure Coding System (HCPCS) level II code *H0040 - ACT services, per diem*.

One unit of ACT service equals one 24-hour day. The current reimbursement rate for H0040 is $70.30. The ACT team psychiatrist or a health services provider in psychology (HSPP) who is an ACT team member must be present at the daily team meeting for the service code to be reimbursed at 100 percent. Follow the billing and modifier guidelines described in banner page *BR200420*, dated May 18, 2004, including billing at 75 percent of the allowed rate with the use of modifiers when the ACT team psychiatrist or HSPP is not in attendance at the daily team meeting.

Hoosier Healthwise and *Medicaid Select* Considerations

Mental health services such as ACT rendered by providers enrolled in the IHCP with a mental health specialty are carved out of risk-based managed care (RBMC) and are billed to EDS as fee-for service claims. Any related services rendered by provider specialties other than those listed below, including pharmacy services, remain the responsibility of the managed care organization in which the member is enrolled. ACT services provided to members in the Hoosier Healthwise or *Medicaid Select* primary care case management (PCCM) programs do not require certification from the primary medical provider (PMP).

The carved-out specialties are as follows:

- Freestanding psychiatric hospitals
- Outpatient mental health clinics
- Community mental health clinics, when the services are provided by a psychiatrist
- HSPP
- Psychologists
- Certified psychologists
- Certified social workers
- Certified clinical social workers
- Psychiatric nurses

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