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South Carolina Assertive Community Treatment

Billing Guidance

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Medical Necessity

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Eligibility Criteria

Entrance Criteria

- Assertive Community Treatment (ACT) requires prior authorization

- Diagnosis include schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), or bipolar disorder, and must reflect a serious and persistent mental illness

- Beneficiaries with a primary diagnosis of substance use disorder, intellectual developmental disorder, borderline personality disorder, and traumatic brain injury are not eligible for ACT

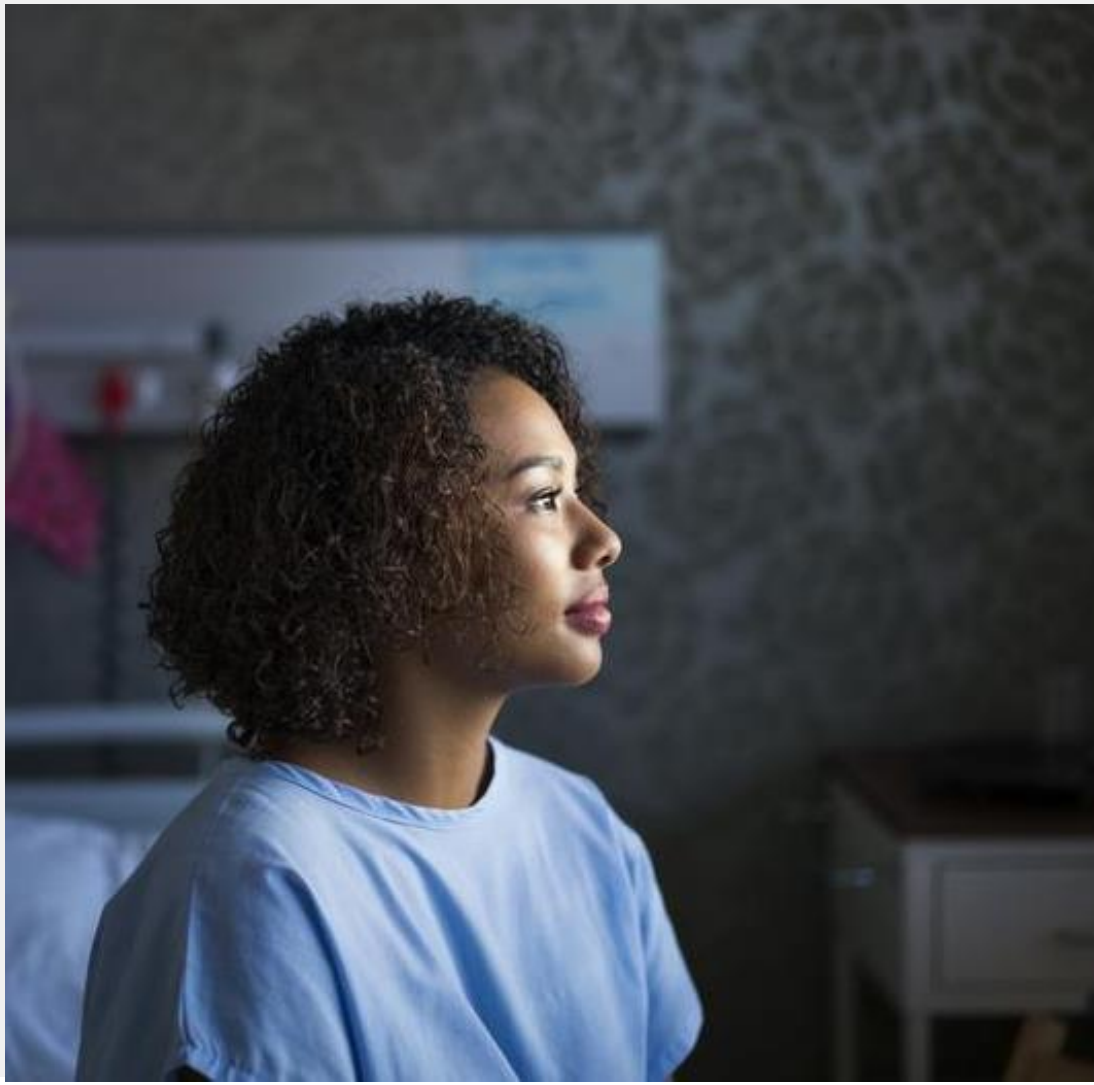
- Initial authorization can cover up to six months

Eligibility Criteria

Entrance Criteria (Continued)

The beneficiary must have significant functional impairment as demonstrated by at least one of the following:

1. Significant difficulty consistently performing the range of routine tasks required for basic adult functioning in the community, or persistent or recurrent difficulty performing daily living tasks without significant support or assistance from others such as friends, family, or relatives.
2. Significant difficulty maintaining consistent employment at a self-sustaining level or significant difficulty consistently carrying out the head-of-household responsibilities.
3. Significant difficulty maintaining a safe living situation.



Eligibility Criteria

Entrance Criteria (Continued)

In addition, the beneficiary has one or more of the following problems which are indicators of continuous high service needs:

1. High use of acute psychiatric hospitalization or psychiatric emergency services.
2. Intractable severe psychiatric symptoms.
3. Coexisting mental health and substance use disorders of significant duration.
4. High risk or recent history of criminal justice involvement.
5. Significant difficulty meeting basic survival needs, residing in substandard housing, homelessness, or imminent risk of homelessness.
6. Residing in an inpatient or supervised community residence but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or requiring a residential or institutional placement if more intensive services are not available.
7. Difficulty effectively using traditional office-based outpatient services.

Eligibility Criteria

Continued Stay

The beneficiary shall be approved for continued stay if the desired outcome or level of functioning hasn't been restored, improved, or sustained over the time frame outlined in the treatment plan,

OR

The beneficiary continues to be at risk for relapse based on current clinical assessment, history, or the tenuous nature of functional gains.

Continuing authorizations can cover up to six months.

Eligibility Criteria

Continued Stay (Continued)

One of the following applies:

1. The beneficiary has achieved current treatment plan goals and additional goals are indicated as evidenced by documented symptoms.
2. The beneficiary is making satisfactory progress toward meeting goals, and there is documentation that supports the continuation of ACT will be effective in addressing the goals outlined in the treatment plan.
3. The beneficiary is making moderate progress, but the specific interventions in the treatment plan need to be modified so that greater gains, which are consistent with the beneficiary's pre-morbid or potential level of functioning, are possible.
4. The beneficiary fails to make progress or demonstrates regression in meeting goals through the interventions outlined in the treatment plan.
5. If the beneficiary is functioning effectively with ACT and discharge would otherwise be indicated, the ACT team services must be maintained when it can be reasonably anticipated that regression is likely to occur if the service is withdrawn, based on one of the following:
    a. There is a documented history of regression in the absence of ACT services or attempts to titrate ACT services downward have resulted in regression.
    b. There is an epidemiologically sound expectation that symptoms will persist, and ongoing outreach treatment interventions are needed to sustain functional gains.

Eligibility Criteria

Discharge Criteria

The beneficiary shall meet at least one of the following:

1. The beneficiary and team determine ACT services are no longer needed based on the attainment of goals as identified in the person-centered plan and a less intensive level of care would adequately address current goals. Standards for transitioning to less intensive services should be consistent with the standards noted in Operations and Structure 9 (OS 9) on the tools for the measurement of assertive community treatment OS subscale.
2. The beneficiary moves out of the catchment area, and the ACT team has facilitated the referral to either a new ACT provider or other appropriate mental health service in the new place of a primary private residence and has assisted the beneficiary in the transition process.
3. The beneficiary and, if appropriate, legally responsible person chooses to withdraw from services and documented attempts by the program to re-engage the beneficiary have not proven successful.
4. The beneficiary has not demonstrated significant improvement following reassessment, several adjustments to the treatment plan over a minimum of three months and all engagement strategies have been documented with no demonstrable results, and:
    a. Alternative treatment or providers have been identified that are deemed necessary and are expected to result in greater improvement as determined by the team's clinical judgment.
    b. The beneficiary's behavior has worsened, such that continued treatment is not anticipated to result in sustainable change as determined by the team's clinical judgment.
    c. More intensive levels of care are indicated by the team's clinical judgment.

Billing Rates and Frequency

ACT Per Diem Rate Development

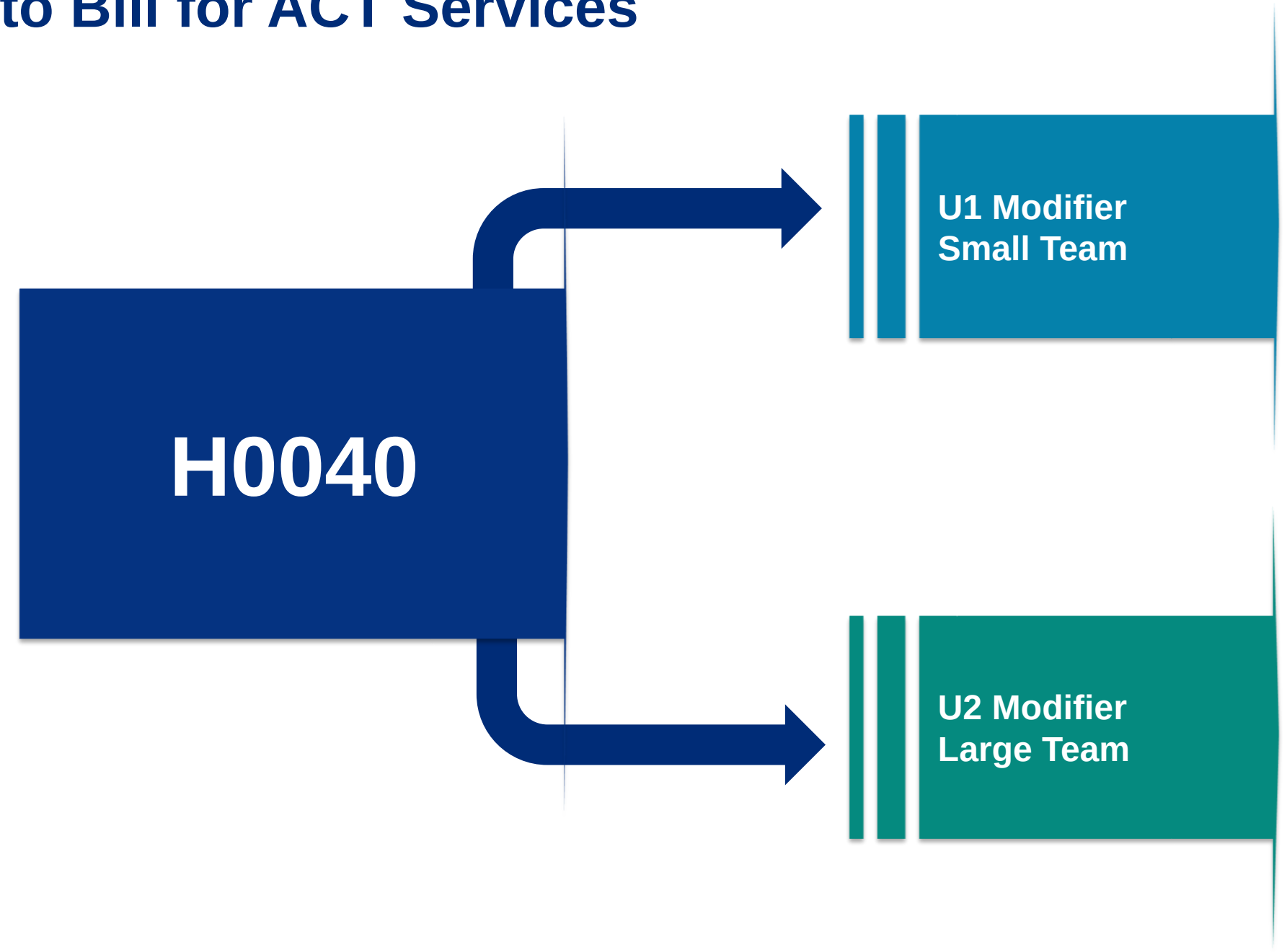
- South Carolina Department of Health and Human Services engaged Milliman to develop the ACT per diem rate.
- Information was gathered from provider engagement meetings and provider data collection surveys to inform ACT provider rates:
  - Provider Inputs:
    - Overall Team Information
  - ACT Staffing (by provider type)
  - Employee Training (by provider type)
  - Costs
  - ACT Fidelity Process

Rates for ACT Services

ACT services will be paid through daily rates designated for both small teams (50 clients or less) and large teams (51 to 129 clients):

Team Size	Daily Rate Per Medicaid Member
Small Teams (50 or less)	$175.65
Large Teams (51–129)	$157.75

How to Bill for ACT Services



When to Bill for ACT Services

Must be face-to-face with the beneficiary or family member

Only ONE per diem per beneficiary per day

9 per diems a month on AVERAGE
15 per diems a month MAXIMUM

15 minutes or longer face-to-face contact (defined as lasting at least 8 minutes)

When Not to Bill for ACT Services

- Group contacts alone are not permitted as a face-to-face contact.
  - Group therapy or group psychotherapy is a form of psychotherapy in which one or more therapists treat a small group of clients together as a group.
- Practitioners may not bill for services included in the ACT per diem and bill for services outside of the per diem.
- Lack of fidelity certification may initiate pending billing status.

ACT and Employment Services

ACT and Employment and Education Services

Employment and education services are rendered by the Vocational Success Specialist (VSS)

VSS utilizes Individual Placement and Support (IPS) Evidence-Based Practice (EBP)

Other team members may assist with services that support beneficiary's employment and education functional outcomes

Activity

How might other team members assist with workplace success?
Place in the chat box a specific team member's role and the activity that may support the beneficiary to function in the workplace.

ACT Per Diem Rate and Restrictions

Billing Guidance

- ACT teams that meet fidelity may bill per diems per month per individual when all other requirements for a visit have been met.
- 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.
  - Per diem rates were developed with a minimum to maximum range.
  - The services and supports outlined in the treatment plan should be followed and implemented even if the maximum per diem rate is met.
  - ACT is an intensive service with multidisciplinary teams, small caseloads, and high frequency and intensity – if billing is below the minimum range, the team may evaluate if this LOC is appropriate.
  - If there are only four to five daily per diems billed a month over three to four months for a particular beneficiary, continuing stay criteria would likely not be met and authorized.
  - A beneficiary that does not require the minimum number of contacts a month should be considered for transition to a lower level of care.

Billing Guidance

How does ACT billing work?

When a beneficiary is authorized for ACT, that is the ONLY behavioral health service they can receive and the ONLY behavioral health service that can be reimbursed

ACT is the most intensive community-based service available and is an all-inclusive service

ACT authorizations are good for a minimum of six months

Authorizations should NOT end early or be paused

ACT claims should supersede all other behavioral health claims

Billing Guidance

Medically Necessary Care

Trina

Trina has been receiving ACT for two years. Up until recently she had been making progress in her recovery goals — she has been living in a halfway house, has enrolled in a HVAC technician certificate program at a local community college, and has a part-time job at Lowe’s Home Improvement. Recently some triggers Trina identified as having the potential to cause a crisis have come up — her favorite aunt passed away, her ex-boyfriend who still uses meth has started texting, and she's not getting enough sleep.

Trina has communicated these triggers with the ACT team, and during a call with the MHP today she said she feels like she's slipping, she's feeling weak, and like she might return to use. She said her anxiety is high and her heart is racing, her depression is worse, and she doesn't know what to do.

Billing Guidance

Medically Necessary Care — Trina

The MHP staffs this with the Team Leader and they arrange the following:

- A telehealth visit with Trina's ACT prescriber to review her current medications, and if any medication adjustments could be made. During the telehealth visit, the prescriber asks if she has been monitoring her blood pressure (Trina has high blood pressure). Trina says no, and the prescriber asks the nurse to complete a quick visit for vital signs.
- The ACT nurse goes to visit Trina. He takes Trina's vitals, finds her blood pressure to be within normal limits, and checks on Trina's medications to make sure she isn't running low.
- The Team Leader updates the Substance Use Specialist on Trina's situation. She goes out in the early afternoon and provides Trina counseling and support, reviews refusal skills and alternate ways to manage depression and anxiety that don't involve substances that Trina added to her relapse prevention plan.
- The Peer Support Specialist goes out in the evening to check on Trina to provide empathy and support.

The ACT team bills one per diem for this day, even though multiple staff have been involved in staffing this case and directly providing services.

Billing Guidance

Medically Necessary Care

Ahmad

Ahmad has been with the ACT team for nine months. Last month, he experienced a behavioral health crisis that resulted in hospital admission. He was in the hospital for 15 days before he was discharged on the first of the month. While he was at the hospital, they changed most of his medication and started him on new medication. Ahmad also has co-occurring physical health issues; he has severe diabetes and chronic obstructive pulmonary disease. He lives in an apartment and uses public transportation.

The ACT nurse picks Ahmad up from the hospital after he is discharged, brings him to the pharmacy to pick up his medications, and then takes him home. Ahmad discloses that while he feels better, he doesn't feel back to normal, and he's worried about taking his new medications correctly. He's also worried about the impact the new medication could have on his blood sugar. The nurse talks to Ahmad about doing daily visits for at least five days in a row so the ACT team can check in on how he's feeling, both mentally and physically, and make sure he's settling back into his routine.

Billing Guidance

Medically Necessary Care — Ahmad

Ahmad completes a telehealth visit with the ACT prescriber while the nurse is still at his apartment. The ACT prescriber reviews the new medication and talks with Ahmad about the symptoms he is experiencing.

Over the next five days, the ACT team supports Ahmad in taking and tracking his blood sugar. ACT staff reports back to the prescriber and nursing staff all the readings. The ACT Peer Support Specialist notices during their visit that Ahmad hasn't been going to his book club like he used to, and that he's also closing all his drapes all the time. These were signs that things were going well before Ahmad's last hospitalization.

The Peer Support Specialist reviews these signs with the team and asks if they can continue daily visits for another 10 days to make sure staff are checking in with Ahmad, encouraging him to get out of his apartment, supporting him in community involvement, and practicing healthy symptom management skills. The team agrees this would be helpful and staffs Ahmad's visits accordingly.

By the 15th of the month, the team has already completed 15 visits and billed 15 per diems, some days having multiple ACT staff contacts, and Ahmad has remained in the community.

The ACT team will continue to provide services for the remainder of the month as medically and clinically needed and will not bill any additional per diems.

When ACT Teams Should Not Bill

- When contacts are not medically necessary
- Time spent in recreational activities
- Educational supports such as teacher and/or tutor
- Childcare or services provided as a substitute for the parent
- Respite care
- Transportation
- Prior to authorization approval
- Services that have not been rendered
- Services not on ACT Treatment Plan
- Services not within provider's scope of practice
- ACT services not outlined in contracts, service manuals, or ACT fidelity standards
- Any intervention or contact not documented with the approved goals and objectives

Billable Place of Service

Billable Place of Service

The ACT team is expected to meet with the beneficiary in environments and at times convenient for them.

Other than psychiatry services, when necessary, ACT is not intended to be provided via telehealth.

Indirect Costs

ACT Indirect and Administrative Costs

- All other contacts, meetings, travel time, training and payment for fidelity reviews were considered in the rate developed and were accounted for in the buildup of the per diem.

- ACT teams do not bill for indirect or administrative costs.

ACT Indirect and Administrative Costs

Administrative (overhead) expenses — all expenses incurred by the provider entity necessary to support the provision of services, but not directly related to providing services to individuals, and may include, but not be limited to:

- Salaries and Wages
- Related Employee Benefits
- Liability and Other Insurance
- Licenses and Taxes
- Legal and Audit Fees
- Accounting and Payroll Services
- Information Technology
- Telephone and other Communication Expenses
- Office and Other Supplies
- Accreditation Expenses, Dues, Memberships, and Subscriptions
- Meeting and Administrative Travel Related Expenses
- Training and Employee Development Expenses, including Related Travel
- Vehicle and Other Transportation Expenses

ACT and Other Services

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Services Provided Concurrently with ACT

Allowable

- Opioid Treatment
- Withdrawal Management Services
- Facility Based Crisis
- Non-Medicaid funded Evidenced Based SE or Long-Term Vocational Supports
- Specialized clinical needs which cannot be provided among the team
- SA Residential Treatment or Adult MH Residential Program
- Psychosocial Rehabilitation for a 30-day Transition Period

Not Allowable

- Individual, group or Family OP
- OP Medication Management
- OP Psychiatric Services
- Partial Hospitalization
- Psychosocial Rehabilitation after 30-day Transition Period
- Nursing Home Facility
- Medicaid-funded Evidenced Based SE or Long-Term Vocational Supports
- Mobile Crisis Management

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