ACT Billing FAQ's

QUESTION: Should all services provided by ACT providers to ACT participants be billed under the H0039t code; including psychiatric care services, nursing services, substance abuse services, peer services, employment services, etc.?

ANSWER: All services provided to an ACT recipient are billed as H0039 except for services provided by a non-ACT team member.

QUESTION: If a team is providing IPS Supported Employment within an ACT team, should the employment specialist use the H0039t code or the H2023t code for IPS services provided to ACT participants?

ANSWER: If the vocational services are provided by a ACT team member who specializes in vocational rehabilitation or supported employment, the services are billed with the H0039. If the supported employment specialist is not an ACT team member, the services are billed using the H2023 code.

QUESTION: Within the ACT model there is an emphasis on having contact with non-professional supports. Is that billable without the participant present? (Family psychoeducation, etc.)

ANSWER: Collateral contacts are a billable activity under the H0039 code.

QUESTION: ACT team members may call or meet with other service providers without the participant present to arrange services for the participant (calling primary care to schedule an appointment, calling social security to inquire about benefits, coordinating with the housing authority around the participant's living situation, etc.) Can these items be billed under the H0039t code without the participant present?

ANSWER: Collateral contacts and case management are a billable activity under the H0039 code.

QUESTION: Can the H0039t code be used when an individual is receiving residential treatment services? What are the considerations around using this code for participants

residing in licensed or unlicensed residential treatment facilities?

ANSWER: Yes, for rehabilitative services not for personal care services. Residential recipients cannot receive both ACT and HK services at the same time.

QUESTION: Should the comprehensive mental health assessment, annual assessment update, comprehensive treatment plan, and treatment plan update by billed using the H0039t code when these services are provided by qualified ACT team members to ACT participants?

ANSWER:Yes

QUESTION: If an ACT Peer Support Specialist is not currently designated as a QMHA by their CMHP, can the Peer Support Specialist use the H0039t code for services provided to ACT participants?

ANSWER: If the peer is providing peer support services, yes, they can bill using the H0039 code without QMHA

QUESTION:If ACT services are provided to ACT participants as a group, can the H0039t code be used to encounter these services. (For example, the required Dual Diagnosis groups, the recommended Illness Management and Recovery groups, and other appropriate therapeutic groups?)

ANSWER: Yes, as long as the group is provided by an ACT team member.

QUESTION: Is information gathered for the purpose of the mental health assessment which is not directly from the participant, but which is considered to be significant in their treatment and is gathered from family members, primary care, etc. billable under the H0039t code?

ANSWER: Gathering information, history, records, collateral contacts etc. are part of the assessment process and assessment can be billed using the H0039 for ACT members when the assessment is completed by an ACT team member.

QUESTION: What would be the considerations for billing the H0039t code for medication drops or medication check-ins for ACT participants?

ANSWER: Medication training and support can be billed using the H0039.

QUESTION: If there are services provided by non-ACT staff members to ACT participants, can non-ACT staff members encounter the H0039t code for these services?

ANSWER: No

QUESTION: Is there a way to encounter outreach under the H0039T code? (For example, multiple outreach attempts to an individual possibly at their home or elsewhere in the community that do not result in a face-to-face contact.)

ANSWER: No

QUESTION: Can integrated diagnostic team meetings for individuals / case coordination / etc. be billed ACT when the person is in the state hospital?

ANSWER: Generally no. Individuals between the ages of 22 and 64 are not eligible for Medicaid when in the state hospital. For individuals over age 64, ACT can be billed for services assisting with discharge and transition from hospitalization to community ACT services.

QUESTION: Can clinical staffing with a psychiatrist who is a member of the ACT team in the same clinic be billed under ACT services if the client is not present?

ANSWER: Yes, consultation is a claimable service, but only one provider can claim for a service at a time. If a client is present? Yes, with same conditions.

QUESTION: Can clinical staffing with a psychiatrist who is not a member of the ACT team in the same clinic be billed under ACT services if the client is not present?

ANSWER: Only services provide by an ACT team member to an ACT recipient can be billed using the ACT code. For a service provided by a non ACT member, the service should be billed with the appropriate HCPCS or CPT code. *If a client is present?* **Same answer.**

QUESTION: What money is available for non-Medicaid individuals who need ACT services?

ANSWER: Each community mental health program has funds to support indigent individuals. The CMHP should be approached to determine the level of funding available for individuals without resources who are in need of ACT.