



Medicaid Questions
OCEACT Annual Statewide Conference 2016
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**Capitation and fee-for-service (FFS) are different methodologies of payment for healthcare providers. The answers provided in this Frequently Asked Questions (FAQ) document refer to billing as it applies to FFS. Questions regarding capitation payments for CCO enrolled individuals should always be directed to the provider’s appropriate CCO.*

Medicaid Questions for OCEACT Annual Statewide Conference 2016

QUESTION: Regarding team-based services provided by providers of different specialties from the same agency. Can we bill for each if the team-based delivery is medically appropriate? Medicare allows for it and Medicaid does in the WRAP program (although the direction at the time was to use different codes to avoid the claims duping but that is no longer an issue since we use individual NPI's). Obviously ACT is often delivered in teams and it would really help if we could get reimbursed for each staff.

A non-ACT situation is when an autistic child also has a mental health issue both the autism specialist and the mental health provider can be reimbursed for the hour long session.

ANSWER: This answer is situation-dependent; for example:

1. An ACT participant is accompanied by an ACT Team staff member to the participant's medical specialist appointment. Because the services are different, both can encounter for services provided. However, each provider (medical provider and ACT provider) can only encounter for the time that the service is actually provided. Each provider is responsible for providing all of the services associated with treatment of the individual while the service is being provided. The ACT team staff member would encounter the ACT code while providing supports prior to and after the appointment, and the medical specialist would bill for the services that were provided during the appointment.
2. Two ACT team staff members (a CADC and a peer) are conducting street outreach to a homeless participant. While the CADC and the peer provide different services, both are providing ACT services. The ACT code should be encountered/billed once (FFS - for as many units as required) for the time both ACT team staff members are engaging the client.

QUESTION: For those programs that are no longer qualified as fidelity programs, at what point do they lose their ability to bill the ACT code? Have some programs been given a grace period during which they can bill anyway? Are CCO's notified of the results of each fidelity review of the CMHP's?

ANSWER: Per OAR 410-172-0490:

ACT Providers

(1) To be eligible for Medicaid reimbursement, ACT services must be provided by a Qualified ACT Provider.

(2) To become a Qualified ACT Provider, an agency must provide the evidence-based practice of ACT, and submit to AMH [HSD] a copy of a fidelity review conducted by an AMH [HSD] approved ACT Fidelity Reviewer, with a minimum score of 114.

An ACT provider who is no longer qualified is prohibited from using the ACT code until they have achieved the minimum fidelity score of 114, as determined by the OHA approved ACT Fidelity Reviewer. Extensions have not been granted (outside of the 90-day re-review period) when a program does not meet the benchmark score of 114. While the current OAR does not indicate who communicates fidelity scores to the CCOs, it is incumbent on the ACT provider to work with their respective CCO to communicate fidelity

scores. A temporary administrative rule effective July 1, 2016, specifies that the provider is responsible for communicating with their CCO.

QUESTION: Can we use a monthly note to document ACT services rather than writing a progress note for each individual service?

ANSWER: No. Each encounter must be documented in the progress note.

QUESTION: Substance abuse services - When we use a substance abuse diagnosis it is rejected by PHtech because it wants a mental health diagnosis with the ACT code. I am curious how to provide Substance abuse services under the ACT code... since it is all a mental health funding stream.

ANSWER: To be eligible for ACT services, the participant must have a primary mental health diagnosis of SPMI. The Substance Use Disorder must be coded as a secondary diagnosis.

Medicaid Questions for OCEACT Annual Statewide Conference 2015

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 Medicaid eligible individuals, ACT can be claimed when providing services to assist with transition and discharge 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? If a client is present?

ANSWER: Yes, this would be considered consultation. Consultation is a rehabilitative service (90887) and can be claimed using the ACT code. When claiming this service using the ACT code, only one provider may bill for the service during a period of time. For example, if an ACT clinician meets with an ACT psychiatrist to consult on a recipient, the psychiatrist and clinician need to split the hour based on the amount of consultation each provider provided. Both the psychiatrist and clinician would bill using the ACT code.

Ex: ACT clinician 30 min H0039 / Psychiatrist 30 min H0039. This is true whether the patient is present or not.

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? If a client is present?

ANSWER: In this scenario, the same answer applies as discussed in the previous question. The only difference, when one of the providers is not an ACT team member, that provider would bill using the appropriate not-ACT code.

Ex: ACT clinician 30 min H0039 / Psychiatrist 30 min 90887 (This is true whether the patient is present or not)

QUESTION: Can clinical staffing with a Primary Care Physician or other medical provider in the same clinic be billed under ACT services if the client is not present? If a client is present?

ANSWER: Similar to the previous two questions, an ACT team provider can bill for consultation with a primary care physician but cannot bill for a service during the same period of time the PCP is claiming a service. Coordination with the PCP round this is necessary.

Ex: ACT clinician 30 min H0039 / PCP 30 min 99341 (This is true whether the patient is present or not)

*Applicable to all questions about billing for consultation by ACT providers with other ACT and non-ACT providers, with or without the patient present, is the requirement that need for provider to provider

consultation services is documented in the assessment and indicated on the treatment plan. Consultative services provided outside a planned approach should only be used during times of emergency or crisis.

QUESTION: When would it be considered appropriate for an ACT team to provide services to individuals in RTFs and RTHs? When would this be considered a duplication of services?

ANSWER: ACT services are generally allowable for residents of licensed residential treatment on a time limited basis to support transition from residential services into community ACT services, or in the case of programs whose primary rehabilitative model is ACT, ACT may be longer term. In either scenario, when an individual receives ACT services, they cannot also receive similar services unless the service is emergency in nature or is a service or provider type not available through the ACT model. Similar services would be any rehabilitative mental health services appearing on the OHA fee schedule.

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 type or level of funding available for indigent individuals in need of ACT services.

Medicaid Questions for OCEACT Annual Statewide Conference 2014

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 be 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