Assertive Community Treatment

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Assertive Community Treatment	Practitioner Level 1, In-Clinic	H0039	U1	U6			$32.46
	Practitioner Level 2, In-Clinic	H0039	U2	U6			$32.46
	Practitioner Level 3, In-Clinic	H0039	U3	U6			$32.46
	Practitioner Level 4, In-Clinic	H0039	U4	U6			$32.46
	Practitioner Level 5, In-Clinic	H0039	U5	U6			$32.46
	Practitioner Level 1, Out-of-Clinic	H0039	U1	U7			$32.46
	Practitioner Level 2, Out-of-Clinic	H0039	U2	U7			$32.46
	Practitioner Level 3, Out-of-Clinic	H0039	U3	U7			$32.46
	Practitioner Level 4, Out-of-Clinic	H0039	U4	U7			$32.46
	Practitioner Level 5, Out-of-Clinic	H0039	U5	U7			$32.46
	Practitioner Level 1, Via interactive audio and video telecommunication systems	H0039	GT	U1			$32.46
	Practitioner Level 1, Via interactive audio and video telecommunication systems	H0039	GT	U2			$32.46
	Multidisciplinary Team Meeting	H0039	HT				$0

Definition of Service: ACT is a recovery focused, high intensity, community based service for individuals discharged from multiple or extended stays in public hospitals, or who are difficult to engage in treatment. The service utilizes an interdisciplinary team to provide intensive, integrated, and rehabilitative crisis, treatment and community support interventions/services that are available 24-hours/7 days a week. The programmatic goals of the service must be clearly articulated by the provider, utilizing best/evidence-based practices for service delivery and support that have the capacity to adequately address co-occurring disorders/issues if needed. Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence-based practices for ACT. Services are directed towards the identified individual consumer and his or her behavioral health care needs based upon the Individualized Recovery Plan and, based on the needs of the individual, may include (in addition to those services provided by other systems)

1. Assistance to the individual in the development of the Individualized Recovery Plan (IRP);
2. Psychoeducational and instrumental support to individuals and their identified family;
3. Crisis assessment, support and intervention; and
4. Psychiatric assessment and care, nursing assessment and care, and psychosocial assessment including identifying strengths and needs and a functional assessment
5. Individualized interventions, which may include:

a. Identification, with the consumer, of barriers that impede the development of skills necessary for independent functioning in the community as well as strengths which may aid the individual in recovery;
b. Support to facilitate recovery (including emotional/therapeutic support/assistance with defining what recovery means to the individual in order to assist individual with recovery-based goal setting and attainment);
c. Service and resource coordination to assist the individual in gaining access to necessary rehabilitative, medical and other services;
d. Family counseling/training for individuals and their families (as related to the person's IRP);
e. Assistance in the acquisition of both mental illness and physical health symptom monitoring and illness self-management skills in order to identify and minimize the negative effects of symptoms which interfere with the individual's daily living (may include medication administration and/or observation and assistance with self- medication motivation and skills);
f. Assistance with financial management skill development;
g. Assistance with personal development and school/work performance;
h. Substance abuse counseling and intervention (e.g. motivational interviewing, stage based interventions, refusal skill development, cognitive behavioral therapy, psychoeducational approaches, instrumental support such as helping individual relocate away from friends/neighbors who influence drug use, relapse prevention planning and techniques etc);
i. Individualized, restorative one-to-one psychosocial rehabilitation and skill development, including assistance in the development of interpersonal/social and community coping and functional skills (i.e. adaptation/functioning in home, school and work environments);
j. Psychotherapeutic techniques involving the in depth exploration and treatment of interpersonal and intrapersonal issues; and
k. Any necessary monitoring and follow-up to determine if the services accessed have adequately met the individual's needs.

Individuals receiving this intensive level of community support are expected to experience increased community tenure and decreased frequency and/or duration of hospitalization/crisis services. Through individualized, team-based supports, it is expected that individuals will achieve housing stability, decreased symptomatology (or a decrease in the debilitating effects of symptoms), decreased medication side effects, improved social integration and functioning, and increased movement toward self-defined recovery.

Target Population	Adults with Serious and Persistent Mental Illness, Adult with Co-Occurring Substance Related Disorders and Serious and Persistent Mental Illness Adults with Co-Occurring Serious and Persistent Mental Illness and MR/DD
Benefit Information	Available to Core Customers in need of Ongoing Services Requires MICP New Episode Request or Update Request (to add as a single service to an existing authorization).

Utilization Criteria	Available to those with LOCUS scores: 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential (transition) 6: Medically Managed Residential (transition)
Ordering Practitioner	Physician, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner)
Unit Value	15 minutes
Initial Authorization	480 units
Re-Authorization	480 units
Maximum Daily Units	96 units
Authorization Period	180 days
UAS: Budget and Expense Categories	Intensive Treatment Services Provider 152 – Adult Mental Health
Admission Criteria	1. Individuals with severe and persistent mental illness that seriously impairs the ability to live in the community. Priority is given to people recently discharged from an institutional setting with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder) or bipolar disorder, because these illnesses more often cause long-term psychiatric disability; **and** 2. Individuals with significant functional impairments as demonstrated by the **inability to consistently engage in at least two of the following:** a. Maintaining personal hygiene; b. meeting nutritional needs; c. caring for personal business affairs; d. obtaining medical, legal, and housing services; e. recognizing and avoiding common dangers or hazards to self and possessions; f. persistent or recurrent failure to perform daily living tasks except with significant support or assistance from others such as friends, family, or other relatives; g. Employment at a self-sustaining level or inability to consistently carry out homemaker roles (e.g., household meal preparation, washing clothes, budgeting, or childcare tasks and responsibilities); h. Maintaining a safe living situation (e.g., repeated evictions or loss of housing); **and** 3. Individuals with **one or more of the following problems** that are indicators of continuous high-service needs (i.e., greater than 8 hours of service per month): a. High use of acute psychiatric hospitals or crisis/emergency services including mobile, in-clinic or crisis residential (e.g., 3 or more admission per year) or extended hospital stay (60 days within the past year) or psychiatric emergency services. b. Persistent, recurrent, severe, or major symptoms (e.g., affective, psychotic, suicidal).

	c. Coexisting substance use disorder of significant duration (e.g., greater than 6 months) or co-diagnosis of substance abuse (ASAM Levels I, II.1, II.5, III.3, III.5). d. High risk or a recent history of criminal justice involvement (e.g., arrest and incarceration). e. Inability to meet basic survival needs or residing in substandard housing, homeless, or at imminent risk of becoming homeless. f. Residing in an inpatient bed or in a 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. g. Inability to participate in traditional clinic-based services; **and** 4. A lower level of service/support has been tried or considered and found inappropriate at this time.
Continuing Stay Criteria	1. Individual meets the requirements above; **and** 2. Continued inability to participate in traditional office setting or community setting at a less intense level of service/supports; **and** 3. Substandard housing, homeless, or at imminent risk of becoming homeless related to the behavioral health issues
Discharge Criteria	1. An adequate continuing care plan has been established; **and one or more of the following:** a. Individual no longer meets admission criteria; **or** b. Goals of the Individualized Recovery Plan have been substantially met; **or** c. Individual requests discharge and is not in imminent danger of harm to self or others, **or** d. Transfer to another service/level of care is warranted by a change in individual's condition, **or** e. Individual requires services not available in this level of care.
Service Exclusions	1. ACT is a comprehensive team intervention and most services are excluded. Peer Supports and Group Training/Counseling are the exceptions. On an individual basis, up to four (4) weeks of service can be provided to ACT consumers to allow an individual to transition to and from ACT and other community services (e.g., Psychosocial Rehabilitation, Community Supports Team & Individual). The transition plan must be adequately documented in the Individualized Recovery Plan and clinical record. 2. Those receiving Medicaid MR Waivers are excluded from the service.
Clinical Exclusions	Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, substance-related disorder.

Additional Service Criteria:

A. Required Components

1. Assertive Community Treatment must include a comprehensive and integrated set of medical and psychosocial services provided in non-office settings by a mobile multidisciplinary team. The team must provide community support services interwoven with treatment and rehabilitative services and regularly scheduled team meetings which will be documented in the served individual's medical record.
2. Team meetings must be held a minimum of 3 times a week and time dedicated to the discussion of the support of a specific individual must be documented in the medical record and submitted as a claim/encounter.
3. Services and interventions must be highly individualized and tailored to the needs and preferences of the individual with the goal of maximizing independence and supporting recovery.
4. At least 60% of all service units must involve face-to-face contact with consumers. At least 80% of face-to-face service units must be provided in locations other than the office (including the individual's home, based on individual need and preference and clinical appropriateness.
5. It is recommended that the ACT Team provide at least 3 face-to-face contacts per week for most individuals on an ongoing basis, and all individuals participating in ACT must receive a minimum of 4 face-to-face contacts per month. The Team must see each individual once a month for the purpose of symptom assessment/management and management of medications.
6. Service may be delivered by a single team member to 2 ACT consumers at the same time if their goals are compatible, however, this cannot be a standard practice. Services cannot be offered to more than 2 individuals at a time (exception: Item A.7.).
7. ACT recipients can receive limited Group Training/Counseling (up to 8 units/week) when a curriculum-based therapeutic group is offered such as Dialectical Behavioral Therapy (DBT). For this to be allowable, the ACT participants must have clinical needs and recovery goals that justify intervention by staff trained in the implementation of the specific curriculum-based therapy. This group may be offered to no more than 8 ACT participants at one time and must be directed by no fewer than 2 staff in order to be billed as Group Training/Counseling. This may be offered for no more than 2 hours in any given week. Only ACT consumers are permitted to attend these group services.
8. "Out-of-Clinic" may only be billed when:
   - Travel by the practitioner is to a non-contiguous location; and/or
   - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
   - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
   - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.

   If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following practitioners can provide Assertive Community Treatment:
   - Practitioner Level 1: Physician/Psychiatrist
   - Practitioner Level 2: Psychologist, APRN, PA
   - Practitioner Level 3: LCSW, LPC, LMFT, RN

- Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's Supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); PP, CPRP, CAC-I or Addiction Counselor Trainees with Master's/Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology (addictions counselors may only perform counseling functions related to treatment of addictive diseases).
- Practitioner Level 5: CPS, PP, CPRP, CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent under supervision of one of the licensed/credentialed professionals above

2. Assertive Community Treatment Team members must include:
   - A fulltime Team Leader who is the clinical and administrative supervisor of the team and also functions as a practicing clinician on the team; this individual must be an independently licensed practitioner and have at least 2 years of documented experience working with adults with a SPMI. The Team Leader who is a registered nurse must hold a four-year degree (BSN).
   - A Psychiatrist on a full-time or part-time basis. The psychiatrist must provide clinical and crisis services to all team consumers, work with the team leader to monitor each individual's clinical and medical status and response to treatment, and direct psychopharmacologic and medical treatment.
   - One fulltime equivalent Registered Nurse who must provide nursing services for all team consumers and who must work with the team to monitor each individual's physical health, clinical status and response to treatment.
   - One-half to one fulltime equivalent who holds a CACI (or an equally recognized SA certification equivalent or higher) who must work on a fulltime or half-time basis to provide or access substance abuse supports for team consumers.
   - A practitioner licensed to provide psychotherapy/counseling under the practice acts or a person with an associate license who is supervised by a fully licensed clinician must provide individual and group support to team consumers (this position is in addition to the Team Leader).
   - One certified Peer Specialist who provides rehabilitation and recovery support functions
   - One to three paraprofessionals (or professionals) who must provide services under the supervision of a Licensed Clinician; one of these staff must be a Vocational Rehabilitation Specialist.
3. It is critical that ACT team members are fully engaged participants in the supports of the served individuals. To that end, effective 1/1/10, no more than 40% of staff can be "contracted"/1099 team members.
4. The ACT team maintains a small consumer-to-clinician ratio, of no more than 12 consumers per staff member. Staff-to-consumer ratio takes into consideration evening and weekend hours, needs of special populations, and geographical areas to be served.
5. Documentation must demonstrate that all team members are engaged in the support of each consumer served by the team including the "time-in" and "time-out" for each staff intervention (excluding the SAP if substance related issues have been ruled out).
6. The ACT Team Leader must be dedicated to a single ACT team. "Dedicated" means that the team leader works with only one team at least 32 hours/week (up to 40 hours/week) and is a full-time

employee of the agency (not a subcontractor/1099 employee). *This requirement is effective January 1, 2010.*

C. **Clinical Operations**

1. Individuals receiving this service must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
2. Because ACT-eligible individuals may be difficult to engage, the initial treatment/recovery plan for an individual may be more generic at the onset of treatment/support. It is expected that the treatment plan be individualized, recovery-oriented after the team becomes engaged with the individual and comes to know the individual. The allowance for "generic" content of the IRP shall not extend beyond one initial authorization period.
3. Because many individuals served may have a mental illness and co-occurring addiction disorder, the ACT team may not discontinue services to any individual based solely upon a relapse in his/her addiction recovery.
4. ACT Teams must be designed to deliver services in various environments, such as homes, schools, homeless shelters, and street locations. The provider should keep in mind that individuals may prefer to meet staff at a community location other than their homes or other conspicuous locations (e.g. their place of employment or school), especially if staff drive a vehicle that is clearly marked as a state or agency vehicle, or if staff must identify themselves and their purpose to gain access to the individual in a way that may potentially embarrass the individual or breech the individual's privacy/confidentiality. Staff should be sensitive to and respectful of individuals' privacy/confidentiality rights and preferences in this regard to the greatest extent possible (e.g. if staff must meet with an individual during their work time, mutually agree upon a meeting place nearby that is the least conspicuous from the individual's point of view).
5. The organization must have policies that govern the provision of services in natural settings and can document that it respects consumers' and/or families' right to privacy and confidentiality when services are provided in those settings.
6. Each ACT Team provider must have policies and procedures governing the provision of outreach services, including methods for protecting the safety of staff that engage in outreach activities.
7. The organization must have established procedures/protocols for handling emergency and crisis situations that describe methods for handling individuals who require psychiatric hospitalization.
8. The organization must have an Assertive Community Treatment Organizational Plan that addresses the following descriptions:
    a. Particular rehabilitation, recovery and resource coordination models utilized, types of intervention practiced, and typical daily schedule for staff
    b. Staffing pattern and how staff are deployed to assure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences, illnesses, and emergencies are accommodated
    c. Hours of operation, the staff assigned, and types of services provided to consumers, families, and/or guardians
    d. How the plan for services is modified or adjusted to meet the needs specified in the Individualized Recovery Plan
    e. Inter-team communication plan regarding consumer support (e.g., e-mail, team staffings, staff safety plan such as check-in protocols etc.)

   f. A physical health management plan
   g. How the organization will integrate consumers into the community including assisting consumers in preparing for employment

D. Service Accessibility

1. Services must be available 24 hours a day, 7 days a week with emergency response coverage, including psychiatric services. Answering devices do not meet the expectation of "emergency response."
2. The team must be able to rapidly respond to early signs of relapse and decompensation and must have the capability of providing multiple contacts daily to individuals in acute need.
3. An ACT staff member skilled in crisis intervention must provide on-call coverage.
4. There must be documented evidence that service hours of operation include evening, weekend and holiday hours.
5. Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient's health. Electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site. The ACT Physician may use telemedicine to provide this service by using the code above with the GT modifier.

E. Additional Medicaid Requirements

1. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Billing/Reporting Requirements

1. All applicable Medicaid, MICP, and other DBHDD reporting requirements must be met.
2. All time spent between 2 or more team practitioners discussing a served individual must be reported as H0039HT. While this claim/encounter is reimbursed at $0, it is imperative that the team document these encounters in the record to demonstrate program integrity AND submit the claim/encounter for this such that future rate setting can be determined.

G. Documentation Requirements

1. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.
2. All time spent between 2 or more team practitioners discussing a served individual must be documented in the medical record as H0039HT. While this claim/encounter is reimbursed at $0, it is imperative that the team document these encounters in the record to demonstrate program integrity AND submit the claim/encounter for this such that future rate setting can be determined.