Intensive Community Based Support

Definitions

Refer to Appendix A and the Telehealth Services Supplement for definition of terms used in this Appendix. The following are definitions specific to Assertive Community Treatment (ACT).

"ACT Service Coordination" means a process of organization and coordination within the multidisciplinary team to carry out the range of treatment, rehabilitation, and support services each individual expects to receive per their written Individual Service Plan (ISP) and is respectful of the individual's wishes. Service coordination also includes coordination with community and vocational resources, including housing resources, consumer self-help and access to advocacy organizations that promote recovery.

~~"Care Coordination" means locating and coordinating services across multiple providers to include sharing of information among health care providers, and others who are involved with an individual's health care, to improve the restorative care and align service plans.~~

~~"Crisis Intervention" means behavioral health care, available 24-hours per day, seven days per week, to provide immediate assistance to individuals experiencing acute behavioral health problems that require immediate intervention to stabilize and prevent harm and higher level of acuity.~~

~~"Health Literacy Counseling" means patient counseling on mental health, and, as appropriate, addiction, treatment, and recovery, and associated health risks including administration of medication, monitoring for adverse side effects or results of that medication, counseling on the role of prescription medications and their effects including side effects and the importance of compliance and adherence.~~

~~"Peer Recovery Support Services" means strategies and activities that include person centered, strength based planning to promote the development of self-advocacy skills; empowering the individual to take a proactive role in the development of their plan of care; crisis support; assisting in the use of positive self-management techniques, problem-solving skills, coping mechanisms, symptom management and communication strategies identified in the plan of care. Caregivers of individuals under age 21 may also receive family support partners as a peer recovery support service when the service is directed exclusively toward the benefit of the individual. Caregivers of individuals under age 21 may also receive family support partners as a peer recovery support service when the service is directed exclusively toward the benefit of the individual.~~

"Skills Restoration" means a service to assist individuals in the restoration of lost skills that are necessary to achieve the goals established in the individual's plan of care. Services include assisting the individual in restoring the following skills: self-management, symptom management, interpersonal, communication, community living, and problem solving skills through modeling, coaching, and cueing.

~~The following definitions found in Chapter II of this manual, apply to this Appendix:~~

- ~~Certified substance abuse counseling assistant (CSAC-A)~~
- ~~Certified substance abuse counselor (CSAC)~~
- ~~Certified substance abuse counselor supervisee (CSAC supervisee)~~
- ~~Licensed mental health professional (LMHP)~~
- ~~LMHP-resident (LMHP-R)~~
- ~~LMHP-resident in psychology (LMHP-RP)~~
- ~~LMHP-supervisee in social work (LMHP-S)~~
- ~~Registered Peer Recovery Specialist~~
- ~~Qualified mental health professional-adult (QMHP-A)~~
- ~~QMHP-eligible (QMHP-E)~~
- ~~Qualified paraprofessional in mental health (QPPMH)~~

~~The following definitions found in Chapter IV of this manual, apply to this Appendix:~~

- ~~Assessment~~
- ~~Care Coordination~~
- ~~Comprehensive Needs Assessment~~
- ~~Counseling~~
- ~~Individual Service Plan (ISP)~~
- ~~Psychoeducation~~
- ~~Treatment Planning~~

Assertive Community Treatment (ACT)

ACT Level of Care Guidelines	
Service Definition **Critical Features & Service Components**	Assertive Community Treatment (ACT) is a highly coordinated set of services offered by a group of medical, behavioral health, peer recovery support providers and rehabilitation professionals in the community who work as a team to meet the complex needs of individuals with severe and persistent mental illness. ACT provides long term needed treatment, rehabilitation, and support services to assist individuals in advancing toward personal goals with a focus on enhancing community integration and regaining valued roles (e.g. worker, daughter, resident, spouse, tenant, or friend). Assertive engagement techniques including rapport-building strategies, facilitating the meeting of basic needs, and motivational interviewing interventions are used to identify and focus on the individuals' life goals and motivations to change. ACT is intended for individuals that have severe symptoms that are not effectively remedied by standard outpatient treatments or who because of reasons related to their mental illness challenge or avoid engagement with mental health services in

	the community. ACT services are offered to individuals in their natural environment and community. An individual who is appropriate for ACT requires this comprehensive, coordinated approach as opposed to participating in services across multiple disconnected providers, to minimize risk of hospitalization, homelessness, substance use, victimization, and incarceration. Critical features of ACT include: • A fundamental charge of ACT is to be the first-line (and generally sole provider) of all the services that an individual receiving ACT needs; • Shared decision-making model, assistance with accessing medication, medication education, and assistance to support skills in taking medication with greater independence; • Team staff availability either directly or on-call 24 hours per day, seven days per week and holidays; • Crisis intervention that is available 24 hours per day, seven days per week, including holidays, via telephone and face-to face contact; • Team provides a higher frequency and intensity of contacts with the individual with a staff-to-individual ratio no greater than 1:9; • Team provides services that are community based, flexible and appropriately adjusted based on the individuals evolving needs; • Being the single point of responsibility necessitates a higher frequency and intensity of community-based contacts between the team and individual, and a very low individual-to-staff ratio. • ACT services are flexible and personalized, adjusting service levels to reflect needs as they change over time. ACT teams must offer and have the capacity to provide the following covered service components to address the treatment needs identified in the initial comprehensive needs assessment: • Assessment • Crisis intervention • Group Therapy* • Health literacy counseling (all interventions related to medication management) • Individual and Family Therapy • Integrated dual disorders treatment for co-occurring substance use*

	• Peer recovery support services;*
	• Skills restoration*
	  ○ Social Skills
	  ○ Communication skills
	  ○ Problem solving skills
	  ○ Wellness self-management and prevention
	  ○ Symptom management
	  ○ Skills required for activities of daily and community living
	  ○ Service components of housing and tenancy sustaining services, pre-employment services and employment sustaining services that involve skills restoration activities such as assistance with social skills, communication skills, problem solving skills and community living skills necessary for an individual to be successful within these activities can be covered when provided by an ACT Team member who meets the staff qualifications for skills restoration (see staff requirements section).
	• Treatment planning
	• ACT service coordination ~~(care coordination)~~ consisting of facilitating access to necessary services as identified in the ISP and assisting individuals to overcome barriers in order to maximize these resources. Activities may include facilitating access to employment and vocational services, housing access and support and other services based on the individual's needs as identified in the ISP. ~~:~~
	  ~~○ Employment and vocational services~~
	  ~~○ Housing access & support~~
	  ~~○ Other services based on the individual's needs as identified in the ISP~~
	
	*As clinically indicated and supported by staff capacity and individual engagement, these services components can be provided in an individual and/or group setting.

Required Activities	The following required activities apply to ACT: **Assessment and Health Literacy Counseling:** • At the start of services, a LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner or Physician Assistant shall conduct an initial assessment consistent with the components required in the Comprehensive Needs Assessment (see Chapter IV for

	requirements), documenting the individual's diagnoses and describing how service needs match the level of care criteria. ○ If a nurse practitioner, who is not a psychiatric/mental health nurse practitioner or a physician assistant conducts the initial assessment it can only be used as the assessment for ACT and cannot be used as a comprehensive needs assessment by the provider for other mental health services (see Chapter IV for details). • A psychiatrist, psychiatric nurse practitioner or a nurse practitioner or physician assistant working under the supervision of a psychiatrist must provide the following: ○ A comprehensive psychiatric evaluation completed as soon as possible but no later than 30-calendar days after admission; ○ Medication prescription monitoring; ○ Contact with the individual, at a minimum, on a quarterly basis. ○ If an individual declines to participate in completing a comprehensive psychiatric evaluation, the team must document the attempt(s) and refusal(s) as well as ongoing efforts to engage the individual in this service component. ○ Participation of the psychiatrist or psychiatric nurse practitioner on the team must be documented such as involvement in team meetings, treatment planning, recommendations to improve psychiatric engagement, and assessment of medical and psychiatric needs. **Treatment Planning:** • ISPs shall be required during the entire duration of services and must be current. See Chapter IV for requirements. The initial ISP shall be completed on the day of admission to the service. • ISPs must be reviewed as necessary at a minimum of every 30-calendar days or more frequently depending on the individual's needs. Refer to Chapter IV for additional guidance and documentation requirements for the 30-calendar day review as well as additional quarterly review requirements. • The treatment planning process should be collaborative but must be directed and authorized by a LMHP, LMHP-R, LMHP-RP, LMHP-S, nurse practitioner or physician assistant as

	evidenced by, at a minimum, the signature of the LMHP, LMHP-R, LMHP-RP, LMHP-S, nurse practitioner or physician assistant. **Crisis Intervention:** Crisis intervention must be available 24 hours per day, seven days per week, including holidays, via telephone and face-to face contact. **Peer Recovery Support Services:** • Registered peer recovery support specialists shall be a part of the ACT team with services to include coaching, consulting, wellness management and recovery strategies to promote recovery and self-direction. Registered peer recovery support specialists may also model and provide education on recovery principles and strategies to fellow team members. If a registered peer recovery support specialist is not available, ACT providers may use staff working on obtaining experience necessary to become a registered peer recovery support specialist to meet this requirement. Only time provided by a registered peer recovery specialist, however, may be included in the time requirements to bill the daily per diem. • ISP goals related to peer recovery support services should be based on the individual's identified recovery needs and achieving maximum independence and autonomy in the community. • The peer recovery specialist shall act as an advocate for the individual, encouraging the individual to take a proactive role in developing and updating goals and objectives in the recovery planning. **Care Coordination:** • Providers must follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV). • In circumstances where a team discharges an individual from ACT to another behavioral health service provider (including another ACT provider) within the team's service area or county, the ACT team should continue to monitor the transition for 31 days to assure that if an individual does not transition with success to these new services, they are able to voluntarily return to the ACT service. During this 31-day period, the ACT Team shall maintain contact with the new provider to monitor the transition in support of that provider's role in the individual's continued recovery and evolving goals.

	• For individuals with a co-occurring substance use diagnosis, the ACT team will provide individual and group therapy for dual disorders treatment based on the principles of Integrated Dual Disorder Treatment and aligned with the individual's readiness/stage of change. In addition, the ACT team will provide active substance use counseling and relapse prevention, as well as substance use education. • ACT teams must offer and have the capacity to provide all of the covered service components identified in the "service description" section of this manual to address the treatment needs identified in the initial comprehensive needs assessment. • If the individual consistently deviates from the required services in the ISP, the provider should work with the Managed Care Organization (MCO) or the fee for service (FFS) contractor to reassess for another level of care or model to better meet the individual's needs.
ACT Medical Necessity Criteria	
Admission Criteria **Diagnosis, Symptoms and Functional Impairment**	Individuals must meet all of the following criteria: 1. The individual must be 18 years or older (as required by Early and Periodic Screening, Diagnostic and Treatment (EPSDT), youth below age 18 may receive ACT if medically necessary); 2. The individual must have a documented Diagnostic and Statistical Manual (DSM) diagnosis that is consistent with a serious and persistent mental illness, including but not limited to, the following DSM categories: Schizophrenia Spectrum and Other Psychotic Disorders; and, Bipolar and Related Disorders. Individuals with diagnoses that fall outside of these categories may be eligible depending on the level of associated long-term disability; in these cases, a Physician letter justifying this exception should accompany the service authorization request. 3. The individual has significant functional impairment as demonstrated by at least one of the following: a. Significant difficulty in consistent performance of the range of routine daily tasks required for basic adult functioning in the community (for example, caring for personal business affairs; obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions; meeting nutritional needs; attending to personal hygiene);

	b. Significant difficulty maintaining consistent employment at a self-sustaining level; or c. Significant difficulty consistently carrying out the head-of-household responsibilities (such as meal preparation, household tasks, budgeting, or child-care tasks and responsibilities); or d. Significant difficulty maintaining a safe living situation (for example, repeated evictions or loss of housing or utilities). 4. The individual has high service needs as indicated by one or more of the following: a. High use of acute psychiatric hospital as defined by multiple admissions within the past two years; b. At least one recent long-term stay of 30 days or more in an acute psychiatric hospital inpatient setting within the last two years; c. High use of behavioral health crisis services as defined by more than four interventions in the last 12 months; d. Intractable (persistent or recurrent) severe mental health disorder symptoms (affective, psychotic, suicidal, etc.); e. Co-occurring mental health and substance use disorder of significant duration (more than six months); f. High risk or recent history of criminal justice involvement (such as arrest, incarceration, probation)as a result of the individual's mental health disorder symptoms; g. Significant difficulty meeting basic survival needs; h. Residing in substandard housing, homelessness, or imminent risk of homelessness as a result of the individual's mental health disorder symptoms; i. Residing in an inpatient setting (e.g. state hospital or other psychiatric hospital) or supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided; j. At risk of requiring a residential or institutional placement if more intensive services are not available; and/or k. Inability to consistently participate in traditional office-based services. Service authorization is required (see service authorization section).
Continued Stay Criteria	Individuals must meet all of the following: 1. The individual continues to meet admission criteria; 2. Another less intensive level of care would not be adequate to support recovery;

Diagnosis, Symptoms, and Functional Impairment	3. ACT participation remains necessary due to continued risk that without the service, the individual is at risk for the following: a. Compromised engagement in or ability to manage medication in accordance with the ISP; b. Increased use of crisis services; c. Inpatient psychiatric hospitalization; d. Decompensation of social and recreational skills (e.g. communication and interpersonal skills, forming and maintaining relationships); e. Decompensation in functioning related to activities of daily living; f. Disruption in the individual's community supports due to individual's challenges with symptoms and functioning (Health, Legal, Transport, Housing, Finances, etc.); g. Decompensation of vocational skills or vocational readiness; 4. The ISP includes evidence suggesting that the identified problems are likely to benefit from continued ACT participation and the goals are consistent with the components of this service; 5. The individual's natural supports, as appropriate, (e.g. individually identified-family/guardian/caregiver) are participating in treatment as clinically indicated and appropriate, or engagement efforts are underway; and 6. Care coordination and discharge planning are documented and ongoing from the day of admission with the goal of transitioning the individual to a less intensive level of care. These efforts should include communication with potential future service providers, community partners, and resources related to school, occupational or other community functioning. Service authorization is required (see service authorization section).
Discharge Criteria	The philosophy that guides the ACT model underscores that individuals participating in the service are expected to struggle with engagement given the severity of their mental illness. Individuals should not be discharged from the service due to perceived "lack of compliance" with the ISP or challenges integrating interventions into their lives towards recovery. The individual meets discharge criteria if any of the following are met: • The individual and team determine that ACT services are no longer needed based on the attainment of goals as identified

	in the ISP and a less intensive level of care would adequately address current goals; • The individual no longer meets admission/continued stay criteria and/or meets criteria for another level of care, either more or less intensive, and that level of care is sufficiently available; • Extenuating circumstances occur that prohibit participation including: a. Change in the individual's residence to a location outside of the service area b. The individual becomes incarcerated or hospitalized for a period of a year or more. c. The individual chooses to withdraw from services and documented attempts by the program to re-engage the individual with the service have not been successful. In circumstances where an individual is discharged from ACT because the individual becomes incarcerated or hospitalized, the provider is expected to prioritize these individuals for ACT services upon their anticipated return to the community, as long as the individual consents to returning to this service and ACT remains an appropriate and medically necessary service for the individual's needs.
Exclusions and Service Limitations	In addition to the "Non-Reimbursable Activities for all Mental Health Services" section in Chapter IV, the following service limitations apply: • An individual can only participate in ACT services with one ACT team at a time. • A service overlap with the services listed below is allowed with documented justification for time needed for admission or discharge transition planning and care coordination. Overlap durations will vary depending on the documented needs of the individual, the intensity of the services and any overlap limitation of the other service but in no instances may exceed 31 calendar days. • Applied Behavior Analysis • ARTS IOP or PHP • ARTS Level 3.1-3.7 • Community Stabilization • Functional Family Therapy • Intensive In Home Services

	• Mental Health Intensive Outpatient • Mental Health Skill Building • Multisystemic Therapy • Outpatient Medication Management • Peer Recovery Support Services • Psychiatric Residential Treatment Facility • Therapeutic Day Treatment • Therapeutic Group Home (TGH) • Standard Outpatient Individual, Group or Family Therapy: Additional overlap with outpatient individual, group or family therapy provided by an LMHP outside of the ACT team may be allowed with documented evidence that the therapy involves a treatment modality benefiting the individual that is not available within the ACT Team. • Office based opioid treatment services (OBOT) and Office Based Addiction Treatment (OBAT) services are allowed simultaneously with ACT. • If an individual is participating in ACT and has a concurrent admission to a Partial Hospitalization Program, the ACT team must conduct care coordination with those providers to assure alignment of the ISP and avoid any duplication of services. • ACT does include non-job specific vocational training, employment assessments, and ongoing support to maintain employment. ~~ACT may provide the necessary medical services that enable the individual to function in the workplace, including ACT services such as a psychiatrist's or psychologist's treatment, rehabilitation planning, therapy, and counseling or crisis management that enable the individual to remain in and/or function in the workplace.~~ Individuals meeting any of the following are ineligible for ACT: • The individual's functional impairment is solely a result of a substance use disorder, personality disorder, developmental disability, traumatic brain injury or autism spectrum disorder without a co-occurring psychiatric disorder; • The individual is at imminent risk of harming self or others, or sufficient impairment exists that a more intensive level of service is required; • The individual's mental health disorder can be effectively treated or recovery process safely maintained at a less intensive level of care;

	• The individual requires a level of structure and supervision beyond the scope of the program; • The individual's primary problem is social, custodial, economic (i.e. housing, family conflict, etc.), or one of physical health without a concurrent mental health disorder meeting criteria for this level of care;
ACT Provider Participation Requirements	
Provider Qualifications	Assertive Community Treatment providers are required to: • ~~To~~ be licensed by DBHDS as a provider of Assertive Community Treatment • ~~To~~ be Enrolled with DMAS • ~~credentialed with the individual's Medicaid MCO for individuals enrolled in Medicaid managed care or the Fee for Service (FFS) contractor for individuals in FFS.~~ • ~~To~~ undergo the standardized rating process using the Tool for Measurement ~~Management~~ of Assertive Community Treatment (TMACT) as determined by DMAS/DBHDS. • ~~To~~ be available either directly or on-call 24 hours per day, seven days per week including holidays. • ~~To~~ operate from a single home office as opposed to a collection of satellite locations to promote team coordination and collaboration. • ~~To~~ follow all general Medicaid provider requirements specified in Chapter II of this manual.
Staff Requirements	ACT service providers must meet the following staff requirements: ~~*ACT Team Sizes*~~ ACT staffing and team sizes must be consistent with 12VAC35-105-1370.~~and definition are consistent with the national standards for the practice.~~ • ~~Small teams serve a maximum of 50 individuals, with one team member per eight or fewer individuals;~~ • ~~Mid-size teams serve 51-74 individuals, with one team member per nine or fewer individuals; and~~ • ~~Large teams serve 75-120 individuals, with one team member per nine or fewer individuals.~~

	~~ACT teams shall be expected to maintain an annual average not to exceed 50, 74, and 120 individuals, respectively.~~ *ACT Team Composition and Roles* ~~The service components that are eligible for Medicaid reimbursement must be delivered by providers who are Medicaid-approved and within professional scope for those services. For information on team composition, see DBHDS Emergency Regulations, 12VAC35-105-1370 available at https://townhall.virginia.gov/L/ViewXML.cfm?textid=14853.~~ As required by DBHDS ~~Emergency~~ Regulation~~s~~ (12VAC35-105-1370), a multidisciplinary ACT treatment team is comprised of the following professionals: • Team Leader • Psychiatric Care Provider • Nurse • SUD/Co-Occurring Disorder Specialist • Registered Peer Recovery Specialist • Vocational Specialist (must be QMHP) • Dedicated Office-Based Program Assistant • Generalist Clinical Staff Member Assessments must be conducted by a LMHP, LMHP-S, LMHP-R, LMHP-RP, nurse practitioner or physician assistant. Psychiatric ~~E~~evaluations and medication prescription monitoring must be provided by a ~~P~~psychiatrist, Psychiatric Nurse Practitioner or nurse practitioner or physician assistant working under a psychiatrist. Care coordination must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-T~~E~~, CSAC*, CSAC Supervisee* CSAC-A* or a QPPMH under the supervision of at least a QMHP-A. Crisis intervention must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-T~~E~~, CSAC*, CSAC Supervisee* or CSAC-A*. Health literacy counseling must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner, Physician Assistant, CSAC*, CSAC Supervisee* or a RN or LPN with at least one year of clinical experience involving medication management.

	Medication administration must be provided by a Psychiatrist, ~~Psychiatric~~ Nurse Practitioner, Physician Assistant or appropriate licensed nursing professional based on ACT team size. Individual, group, and family therapy must be provided by a LMHP, LMHP-R, LMHP-RP or LMHP-S. Peer recovery support services must be provided by a Registered Peer Recovery Specialist. Supervisors of Registered Peer Recovery Specialists must complete the DBHDS Peer Recovery Specialist Supervisor Training. Skills restoration must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-T~~E~~ or a QPPMH under the supervision of at least a QMHP-A. Treatment Planning must be provided by an LMHP, LMHP-R, LMHP-RP, LMHP-S; QMHP-A, QMHP-C, QMHP-T~~E~~, CSAC*, CSAC-Supervisee*. **CSACs, CSAC Supervisees and CSAC-As may only provide services related to substance use disorder treatment per § 54.1-3507.1 and § 54.1-3507.2* ~~RNs, LPNs, and~~ Nurse Practitioners shall hold an active license issued by the Virginia Board of Nursing. RNs and LPNs shall hold an active license issued by the Virginia Board of Nursing or hold a multistate licensure privilege pursuant to Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia. Physicians and Physician Assistants shall hold an active license issued by the Virginia Board of Medicine.
ACT Service Authorization and Utilization Review	
Service Authorization	ACT requires service authorization and the service providers delivering ACT shall meet the provider qualifications listed above. Providers must submit service authorization requests to the Medicaid MCO for individuals enrolled in managed care or the FFS service authorization contractor for individuals in FFS. Providers shall submit service authorization requests within one business day of admission for initial service authorization requests and by the requested start date for continued stay requests. If submitted after the required time frame, the begin date of authorization will be based on the date of receipt. If additional ACT services are clinically required, the provider shall submit an authorization request to the FFS service authorization

	contractor or MCO through a continued stay service authorization request submitted no earlier than 24 hours before the requested start date of the continued stay and no later than the requested start date accompanied by the following items: 1. A Comprehensive Needs Assessment (see Chapter IV for requirements); **and** 2. A current addendum to the above assessment, (can be in a progress note) that briefly describes any new information impacting care, progress and interventions to date, and a description of the rationale for continued service delivery, and evidence the individual meets medical necessity criteria; **and** 3. Individual Service Plan Additional information on service authorization is located in Appendix C of the manual. Service authorization forms and information on Medicaid MCOs processes is located at www.dmas.virginia.gov/for-providers/behavioral-health/training-and-resources/.
Documentation and Utilization Review	In accordance with 42 CFR § 441.18, individuals must have free choice of case management providers and cannot be required to or prohibited from receiving case management as a condition of receiving a state plan service such as ACT. Should an individual choose to participate in targeted case management services along with ACT, the providers of each of these services will need to clearly and substantially document the need for both and documentation must demonstrate that the two services are not being duplicated. Refer to Chapter IV and VI of this manual for additional documentation and utilization review requirements.

ACT Billing Guidance

One unit of service is one day. To bill the per diem unit, qualified ACT team members must provide, at a minimum, a total of 15 minutes of face-to-face covered services during the calendar day that the per diem is billed. Care coordination activities provided by a qualified ACT team member must be provided face-to-face in order to be included in the 15-minute minimum required to bill the per diem.

After hours crisis intervention provided by a qualified ACT team member through audio only telehealth may be included in the 15-minute minimum required to bill the per diem if the provider determines that the crisis can be safely managed through telephonic services as specified in the ISP.

Licensed direct care staff shall provide services within the scope of practice for their license. Practitioners may not bill for services outside of the ACT per diem (H0040) rate while individuals are receiving ACT services.

The Per Diem Rate includes any of the following service components provided by a qualified provider:

- Assessment
- Care Coordination
- Crisis Intervention
- Health Literacy Counseling
- Integrated dual disorders treatment for co-occurring substance use
- Peer Recovery Support Services
- Skills Restoration
- Treatment Planning
- Therapy (individual, group and family)

Crisis intervention activities provided by the ACT team shall not be reimbursed separately. While the ACT team should be employed whenever possible as the crisis responder, when immediate crisis intervention is clinically required, billing for concurrent Mobile Crisis Response Services (H2011) is allowable. The ACT provider should coordinate care with the Mobile Crisis Response provider.

Coverage of services delivered by telehealth are described in the "Telehealth Services Supplement". MCO contracted providers should consult with the contracted MCOs for their specific policies and requirements for telehealth.

Billing Code	Unit	Description	Notes	Provider Qualifications
H0040 and modifier as appropriate	Per Diem	Assertive Community Treatment	~~ACT providers may bill only~~ Only one per diem per individual per day may be billed. ~~All other contacts, meetings, travel time, etc. are considered indirect costs and is accounted for in the buildup of the per diem rate.~~	Service components must be provided by a qualified provider (see Provider qualification and staff requirements section)
H0040 and modifier as appropriate	n/a	Comprehensive Needs Assessment		LMHP, LMHP-R, LMHP-RP, LMHP-S,

				Nurse Practitioner, Physician Assistant
90791, 90792	n/a	Psychiatric Diagnostic Evaluation	Providers should bill CPT codes appropriate for the activity and professional conducting the assessment when an assessment is completed but the individual does not enter the service.~~This code should be used when a LMHP, LMHP-R, LMHP-RP or LMHP-S conducts the comprehensive needs assessment, determines that the individual does not meet MNC and will not enter the service~~.	~~LMHP, LMHP-R, LMHP-RP, LMHP-S,~~ Qualified providers
~~90792~~	~~n/a~~	~~Psychiatric Diagnostic Evaluation~~	~~This code should be used when a psychiatrist, physician assistant or nurse practitioner conducts the comprehensive needs assessment, determines that the individual does not meet MNC and will not enter the service.~~	~~Psychiatrists, Physician Assistants, and Nurse Practitioners~~

~~In accordance with 42 CFR § 441.18, individuals must have free choice of case management providers and cannot be required to or prohibited from receiving case management as a condition of receiving a state plan service such as ACT.~~

~~Mental health case management (MHCM) is a distinct service and may only be provided by a DBHDS licensed mental health case management provider (see Chapters II and IV of this manual for additional details). Should an individual choose to participate in MHCM, or any other targeted case management service, along with ACT, the providers of each of these services will need to clearly and substantially document the need for both and documentation must demonstrate that the two services are not being duplicated.~~

~~Rates for ACT are tiered by~~Providers shall bill with the modifier that reflects their team size and fidelity status, ~~and each combination of these categories has an associated modifier to be used with the ACT procedure code to identify the appropriate rate.~~ at the time of service delivery, as reflected on the Center for Evidence-Based Partnerships (CEP-VA) at Virginia Commonwealth University (VCU) website: www.ebpfinder.org

Team Size	Fidelity Status	Team Size Standards	~~Corresponding TMACT Score~~	Modifier
Large	Base	Team serves between 75-120 individuals, with one team member per nine or fewer individuals	~~3.4-3.9~~	none
Medium	Base	Team serves between 51-74 individuals, with one team member per nine or fewer individuals	~~3.4-3.9~~	U1
Small	Base	Team serves a maximum of 50 individuals, with one team member per eight or fewer individuals	~~3.4-3.9~~	U2
Large	High	Team serves between 75-120 individuals, with one team member per nine or fewer individuals	~~4.0-5.0~~	U3
Medium	High	Team serves between 51-74 individuals, with one team member per nine or fewer individuals	~~4.0-5.0~~	U4
Small	High	Team serves a maximum of 50 individuals, with one	~~4.0-5.0~~	U5

		team member per eight or fewer individuals		