Assertive Community Treatment (pdf)

1. Do we have to specify all the documentation elements pertaining to ACT/CST activity codes for DHS? Currently, we use 14 different activity codes for ACT such as ACT-Individual, ACT Client-centered consultation, ACT -Treatment plan development, ACT-Crisis intervention, ACT-Case management, etc. In the Service Definition and Reimbursement guide, DHS service activity codes for ACT are 9A and 9B and all the 14 activity codes that JWC has for ACT gets converted into 9A or 9B. Do we really need 14 different activity codes for ACT or can we get by using two codes?

   Answer: Rule 132 doesn't require all these distinctions.

2. I need clarification on the MHA and the ITP for ACT. An ACT consumer would already have the Comprehensive MHA and ITP completed by an ACT staff and all services would indicate ACT services pertaining to ACT staff only, while they are in ACT. Do the non-ACT staff at the residential setting generate a new MHA and ITP pertaining to crises and stabilization for 30 days prior to providing services in the residential setting or would the previous MHA and ITP from ACT staff be enough?

   Answer: If the MHA and ITP already include more than just ACT as a recommended service, then you'll be ok. However, if ACT is the only service on the MHA and ITP and then in residential for 30 days non-ACT staff provide CSR or therapy or anything else, those services will not be claimable because they're not on the MHA or ITP.

3. Can the RN be both the ACT leader and ACT RN if s/he meets all the criteria for the team leader?

   Answer: The ACT team leader and the ACT RN position are each full time positions, and therefore, cannot both be filled by a single person.

4. Our agency has an ACT program and we want to make sure we are billing correctly in the situations when we have an ACT client in transition or in crisis. If an ACT client is coming out of an inpatient treatment and needs transition to an independent living arrangement, we can put them into our supervised residential program. There they will receive services from non-ACT staff. Same in the situation that we are attempting to prevent hospitalization, or are dealing with another type of crisis. We checked with Network staff who said it was ok. Please confirm this. Then confirm that we need to bill for codes other than ACT as stated in this Q&A. Somewhere along the way we were given the impression that we could keep an ACT client in supervised residential for up to 30 days. Is there a time limit on these transitional services?

   Answer: A client who is receiving ACT services should receive all of their services from the ACT team. If the individual has a psychiatric crisis and crisis residential services are likely to avert a psychiatric hospitalization, the individual can receive both ACT services and services from the staff at the crisis residential setting for a maximum of 30 days. The crisis must be related to a psychiatric crisis. During the period that the individual is in the residential setting, the ACT team may continue to bill for ACT services and the residential staff may bill for their services - Community Support Residential and therapy for example. The billing rule that only one staff can bill for face-to-face contact with the client at the same time remains in effect. And, all services must be on the ITP.

5. 1) How do we bill for a client whose status with ACT is pending? Does the ACT staff bill the case management codes to do the assessment and ITP and then convent to ACT codes after acceptance? 2) We have some clients who are pre-approved for ACT but do not yet have an assessment completed by ACT staff or an ITP with ACT services; how do we code them during the interim?

   Answer: Until a new consumer is in ACT, you should bill for the service provided. In this case it appears that those would be mental health assessment, case management and treatment plan development, review and modification. If the consumer already has an ITP and has been receiving other services from your agency, those other services may continue for 30 days as the consumer transitions to ACT.

6. Is transportation built into the ACT rate? We have an ACT client that has no way to get back to us in Rockford (he is in Aurora) and the only option we have is to go get him.

   Answer: It is interesting that you would transport someone from Aurora to Rockford for ACT. ACT is primarily a community service provided to a consumer in his own community. Yes, transportation is built into all rates. Transportation as a unique service is not billable.

7. If a few ACT staff are all absent/sick at the same time and we use non-ACT staff to fill in for the day, how do we bill? Should we use the ACT code or other coding?

   Answer: You may bill for ACT. This should be done only as necessary to cover periodic staff absences.

8. When the ACT nurse is out sick and another nurse fills in, can s/he bill using the ACT code?

   Answer: Yes, a nurse who is substituting as an ACT team member may bill ACT.

9. It is my understanding that the team leader is to be dedicated full-time to ACT, is that correct?

   Answer: You are correct. Each ACT team is to have one full-time team leader.

10. What is the role of an Advanced Practice Nurse especially as it relates to her/his role in ACT?

    Answer: In 132.150(h)(5)(B)(ii) the rule allows an advanced practice nurse to substitute for up to half of the psychiatrist's time.

11. Can two staff bill for the same ACT consumer at the same time e.g., Doctor is providing psychiatric services and another staff is providing consultation to the doctor about the consumer's progress on the treatment plan?

    Answer: If the psychiatrist is not a member of the ACT team, she/he may bill medical services provided directly to HFS. The other staff may bill DHS for ACT services. However, if the doctor is a member of the ACT team, only one may bill for ACT services for any one client at any one time.

12. Should the comprehensive assessment be billed as an ACT code note or a mental health assessment (to differentiate between the two)?

    Answer: All services to ACT clients must be billed as ACT.

13. Can a veteran receive services from an ACT team and psychotherapy/psychiatric services from the Veterans Administration (VA) at the same time, since the VA is not a Rule 132 biller?

    Answer: Yes.

14. Rule 132 states that the rehabilitative services associates on an ACT team will "function as the primary practitioners for a caseload of clients . . . " Does this mean that each ACT client must be assigned to a particular associate for the purpose of receiving services, i.e., a caseload approach? If so, what does "primary" mean exactly -- that the client must receive the majority of services, such as symptom management and work services, from that assigned associate, or does it mean something else?

    Answer: No, RSA is the minimum level of staff required for the provision of ACT services. The client should have a team member who serves as their primary contact, someone who will be their primary advocate. This staff person may also be an MHP, QMHP or LPHA.

15. Can an ACT client attend Drop-In Center?

    Answer: Yes, but it's not billable.

16. How will psychiatrist time be measured?

    Answer: It is up to the provider to document the psychiatrist time in ACT so that reviewers can verify that she/he is working in ACT 10 hours per week for every 60 clients served in ACT.

17. Can ACT services be provided in same office where non-ACT services are provided?

Answer: Yes.

18. If an ACT team fails to meet staffing requirements for 31 days, how will DHS know?

    Answer: Through the post payment review and survey process. When found through this process, money will be recovered.

19. When there is no official ACT team after 30 days, can the provider immediately bill for CS-Individual, Group?

    Answer: Service(s) must be on the client's ITP and the provider must be certified to provide the services.

20. The Service Definition and Reimbursement Guide states that ACT includes "medication prescription, administration, monitoring and documentation." This seems clear except that presently Medication Administration is an event-mode service which I thought was recognition of the fact that often it takes less than eight minutes to properly administer medications. How will an agency get credit/bill for this valuable service when rendered by a member of the ACT Team to an ACT client if the service lasts less than eight minutes?

    Answer: ACT was intentionally developed to be a comprehensive service. When the rate was developed, all services were considered. Please read the definition to see how ACT incorporates many different services, including medication administration. Medication management services should be billed as ACT services for ACT clients. If the service takes less than seven 1/2 minutes, combine the service with other ACT services to reach the minimum number of minutes for billing a unit. You are not reporting distinct Rule 132 services for an ACT client. There are only two billing codes for ACT - one code for individual and one code for group.

21. When an ACT client is receiving "other services"; i.e., Crisis residential and Med. administration, by a non-ACT staff, is it billed under ACT or Crisis Intervention?

    Answer: We assume that the scenario is an ACT client who needs crisis residential services to stabilize a crisis. In this instance, the services provided by non-ACT staff would be billed as the service provided. Only services provided by ACT staff can be billed as ACT services, and the ACT team is responsible for crisis intervention with their clients. All services must be on the ITP.

22. How can the admission note be used to begin billing for ACT, when the client needs to be authorized by the ASO for ACT? There is also no mention of ACT services on the sample admission note that we were provided.

    Answer: Once services are authorized by the ASO, an admission note may be used to initiate services prior to the completion of a mental health assessment for a client authorized for ACT prior to the completion of a comprehensive assessment. An Admission Note is effective for a maximum of 30 days. When an Admission Note was completed to initiate services, the ITP shall be developed, following the completion of the comprehensive assessment, within 30 days after the client's date of admission. Mental health services may be provided concurrently with ITP development if the comprehensive assessment report is completed, or the Admission Note is signed and dated by the QMHP. An admission note simplifies the paperwork required for the first 30 days after service authorization, allowing services to begin promptly. The sample was not intended to be the only possibility; ACT may be added to it.

23. In Rule 132 Q&A under ACT, there is a question that addresses the situation of the ACT nurse being out sick/vacation. The answer states that the agency must have a back-up plan in place. a) Can a non-ACT agency nurse fill-in during sick leave, vacations, etc? b) Is the fill-in nurse allowed to bill under ACT when s/he is not part of the ACT team?

    Answer: a) Yes. b) Yes. She is considered a part of the team while filling in for the nurse position on the ACT team.

24. I am an employment specialist on an ACT team. On the treatment plan where it lists services provided for Supported Employment, my name is listed in the column under Staff. Is that okay or should the case manager and other staff be listed?

Answer: The same rules apply to treatment planning whether it is Medicaid or non-Medicaid. We expect to see "the responsible staff" listed by name but that does not mean that s/he is the only staff that can provide the service.

25. In a discussion with our ACT supervisor, she stated that there are nine clients in the hospital. Is it correct that no billing can occur while they are in the hospital, or is the hospitalization considered "receiving residential services to stabilize a crisis?"

    Answer: The ACT team should focus on the client's transition to the community. Services may be provided in the hospital but they cannot duplicate services that are provided in the inpatient setting. The exception to the exclusion for ACT, "receiving residential services to stabilize a crisis", relates to crisis residential services, not hospitalization.

26. An agency has ACT clients who get medication through sources such as the VA, private psychiatrist, etc. One even receives therapy from a private therapist. This is assumed to be acceptable since these are their preferences. Can you confirm that this is correct, or does it mean that ACT cannot serve them because they choose an outside therapist?

    Answer: The rate for ACT includes all of these services (psychiatry, therapy). You should reevaluate the need for ACT if the client is able to maintain relationships with private practitioners. CS-Team or a less intensive service may meet the needs of the client.

27. Is there a time frame during which an agency should continue to try and connect with an ACT consumer before they consider discharging him/her?

    Answer: The source document used to develop the Rule definition defines "persistent engagement" as at least two attempts per week for three months.

28. If an ACT consumer is placed in an inpatient psychiatric facility, inpatient medical hospital, or nursing home for rehabilitative services, how long does the ACT program keep them active and how long can ACT be re-authorized when a consumer may be in another setting for more than 6 months?

    Answer: If a consumer is going to be in an inpatient setting for 6 months, it would seem that ACT is not an appropriate service.

29. An agency has a consumer who insists on seeing a psychiatrist in the community who is not the ACT psychiatrist. Can this consumer remain in ACT? The ACT psychiatrist will not be comfortable filling out a form to indicate that there is medical necessity for ACT on someone they have not seen. Can the community psychiatrist complete the pre-authorization and/or reauthorization section of the form that requires completion by ACT psychiatrist?

    Answer: The rate for ACT includes psychiatric services, but the psychiatrist is not the only ACT staff who recommends medical necessity. You should re-evaluate the need for ACT if the client is able to maintain relationships with private practitioners. CS-Team or a less intensive service may be more appropriate to address the client's needs.

30. If a client is in crisis residential, both the services in the residential program and ACT team are reimbursable. If an ACT client was assessed to need this service in lieu of psychiatric hospitalization, would crisis center staff use billing codes specific to the service and not ACT codes?

    Answer: Yes, as long as there is an authorized referral to crisis residential. When general crisis services are provided to clients in ACT, the crisis services are to be provided by a member of the ACT team and billed as ACT.

31. An ACT client receives Medicare. When this member sees the ACT doc, would ACT or Medicare be billed for this service?

    Answer: ACT is not a covered Medicare service. ACT team services and the corresponding rate include ongoing involvement of a physician. Services by the physician assigned to the ACT team to ACT clients should be billed to DHS as an ACT service.

32. An ACT client receives Medicaid. When this client sees the ACT doc, would ACT or Medicaid Professional be billed?

    Answer: The service should be billed to DHS as an ACT service. The ACT client is receiving an ACT service from one of the team (a doc).

33. How does the crisis staff at the hospital interact with the ACT team that is required to provide 24 hour crisis intervention? How would the hospital staff know that this is an ACT consumer and that the ACT team should handle the crisis?

    Answer: Ideally, the ACT team is viewed by the consumer as a front line crisis intervention and is readily accessible to the consumer. However, in some cases, an ACT team may be notified after the fact that an ER visit has occurred. In those cases, the ACT team should immediately follow up on crisis issues, and work with the consumer to redirect immediate crisis needs back to the team.

34. It would be very difficult for some of our ACT staff to be available on 24/7 basis, e.g., single parent, caretaker for a family member. How do we handle that?

    Answer: Not all members of the team need to be available at the same time. Minimum staffing and team size is based in part on the minimum number of staff to ensure that at least one team member is available at all times with back up from other team members as needed.

35. If crisis workers are trained on the ACT model, can they handle crisis services for ACT consumers?

    Answer: No.

36. Will we be paid if we provide crisis services to consumers in ACT with staff who are not on the ACT team?

    Answer: The Rule clearly states that all services including crisis intervention are to be provided by the ACT team.

37. Do the prosumer, MISA worker and vocational worker have to be part of the 6 FTE staff? If not, how many hours would these staff have to work in ACT to maintain the fidelity?

    Answer: These staff are expected to be part of the 6 FTE staff/team.

38. What specific clinical functions must be performed by the team leader?

    Answer: Team leader functions may include clinical supervision of team members, constant review of status/symptomatology of consumers served by the team, back up/clinical consultation for crisis, and direct service, as well as coordination duties including ensuring 24/7 scheduling/coverage, ensuring appropriate and current clinical record documentation, etc.

39. If the team leader is licensed, does all ACT consumer MH assessments, and serves as LPHA for all ACT consumers, does this meet the "clinician" criteria for the ACT team leader?

    Answer: The ACT team must have a full time, dedicated team leader who is licensed.

40. Can the MISA specialist also be a person in recovery?

    Answer: Yes, if certified as a CRSS.

41. Does the MISA competency require CADC certification or can it be other training as well?

    Answer: CADC certification is not required. Provider should be prepared to demonstrate documented certification or training and/or experience upon request.

42. Is there any limit to the number of ACT team members, i.e., a team with many members - RSA in the field?

    Answer: The Rule does not limit the maximum team size. Agencies will be expected to demonstrate that they are able to serve the consumers on the ACT teams in the manner prescribed on their respective treatment plans.

43. To be an ACT team member, do you have to attend all meetings when you are on duty?

    Answer: In order to meet the requirement of evidence of "team functioning," it would be expected that all team members attend the preponderance of team meetings.

44. Will the state help providers identify consumers in recovery for the ACT team?

    Answer: The ACT provider must arrange for hiring a person in recovery certified as a CRSS. The Department's Recovery Support Specialists may assist in identifying individuals for interviewing.

45. Is ACT for adults only?

    Answer: Yes, it is for individuals 18 years of age or older.

46. Research indicates that MISA issues are most effective in group settings. Is a group allowed in ACT?

    Answer: Yes, groups will be allowed up to two hours per week per individual in ACT with group size not to exceed 8 persons.

47. What is the interface between SASS and ACT?

    Answer: ACT is a service that may be billed under SASS for individuals who are 18 - 21 when medically necessary and authorized.

48. Can a person in ACT participate in a group that is not part of ACT?

    Answer: All services are to be provided by the ACT team unless the person is transitioning to other services.

49. We all know that staff turnover occurs and that there will be vacancies on the ACT team. What is the grace period for staff vacancies before ACT billing has to be suspended?

    Answer: 30 days.

50. Has the Division considered a waiver of the requirement that the team leader for the ACT team is a licensed clinician?

    Answer: No, the Division expects a licensed clinician to provide the clinical direction to the team.

51. Does the psychiatrist on the ACT team have to agree to provide face to face crisis services?

    Answer: This is not specified in the service definition though it is likely that a consumer may need face to face crisis intervention with a psychiatrist on occasion.

52. Are the only diagnoses listed in the presentation materials a requirement for getting ACT services? For example, major depression is not listed, but a consumer could have multiple hospitalizations with that diagnosis.

    Answer: Yes, the list is limited as noted. The ACT admission criteria diagnosis list reflects diagnoses for which research has found the evidence based practice of ACT to be effective.

53. In addition to the required staff, can other staff, e.g., Techs and RSAs be involved in ACT?

    Answer: The staffing requirements in Rule 132 are what should be followed.

54. Is there a requirement regarding how much time, per team member, must be devoted solely to the ACT program? Can any member of the ACT team, such as a Vocational Specialist, work in another program as well?

    Answer: Team members identified to meet the core staffing requirements must be solely dedicated to the ACT team.

55. It appears that persons with Borderline Personality Disorder will no longer be served by ACT. These individuals are often at the highest level of risk, needing the most intensive services. Why are they not an included diagnosis to be served by ACT?

Answer: The ACT admission criteria diagnosis list reflects diagnoses for which research has found the evidence based practice of ACT to be effective. Other Rule 132 services are available to be delivered at intensive levels as indicated by consumer need.

56. How does one avoid burn-out when available 24/7?

    Answer: 24/7 availability is by the 'team' not by an individual staff member. Team size was established with consideration for adequate numbers to ensure at least one staff member is on call at any one time - not that all are on call at all times. Only ACT requires 24/7 primary availability by the team.

57. Are CST & ACT staff requirements the same?

    Answer: No. Please see the staff requirements in each service definition in Rule 132, Section 132.150.

58. What kind of license does an ACT team leader need?

    Answer: Please see the definition of licensed clinician in Section 132.25 of Rule 132.

59. If crisis services are provided to an ACT consumer by a worker who is not on the ACT team, may we bill for that crisis service?

    Answer: ACT team is responsible for providing crisis services to all clients receiving ACT.

60. Is there a window for CADC & MISA Specialist to be in place? (we need time for recruitment, the application process, and testing).

    Answer: Certified CADC or MISA Specialists are not expressly required under the Rule. Where a specific reference is made to co-occurring treatment, the requirement is documented training, experience, or certification. An agency may elect to have its own co-occurring training curriculum that is a regular part of all staff training. Staffing per Rule 132 must be in place in order to be certified for ACT.

61. Why is there a restriction on ACT & PSR or other services? If it's truly non-linear, we should be able to give the consumer whatever services they need, when they need them.

    Answer: ACT is an all inclusive service and can include skills training interventions like those delivered in a PSR program.

62. May ACT consumers participate in CS-Group?

    Answer: No. ACT consumers may be served by ACT staff under limited conditions in a group setting. See the ACT service definition, Rule 132, Section 132.150.

63. How does SASS work for a 19 year old in ACT? Who bills what to whom?

    Answer: ACT is a Rule 132 service that may be billed under SASS. All SASS billing is directed to HFS. And, ACT must be authorized to be billed.

64. Can an ACT consumer be in PSR?

    Answer: No. ACT is a comprehensive service that includes skill training and development.

65. Upon occasion, is it permissible for one ACT Team member to serve two clients at the same time, and bill for both clients for the whole time?

    Answer: The service is billable as ACT Group, and a maximum of 2 hrs/wk group services are billable.

66. If a consumer is determined to need ACT services, and the provider agency loses certification, who would then provide this service, and is there a required referral process in place?

    Answer: The provider has a responsibility to transition clients to other Rule 132 services that meet their needs.

67. May ACT consumers live in residences with 24 hour support?

Answer: No, except for a 30-day transition. The team approach supports the client in remaining independent in the community. Those kinds of supports are not necessary in 24 hour residential settings.

68. Will SASS be paid if they complete a pre-hospitalization screening on an ACT client at an ER; how will these participants be screened out prior to calling SASS; should they not be screened out?

    Answer: A pre-hospitalization screening will be reimbursed if needed, even if the client does not indicate that he/she is an ACT client.

69. A patient in ACT decompensates and the psychiatrist recommends hospitalization. The ACT psychiatrist is not on staff at the community hospital. Is the community hospital crisis staff expected to provide a fee service? What is the role of ACT on inpatient treatment?

    Answer: The ACT Team should collaborate with the hospital staff to ensure that there are adequate supports when the client returns to the community.

70. If there is a vacancy for more than 31 days on an ACT team, and an organization is certified for CS-Team, will billing from ACT team convert to CS-Team, or be billed as CS-Team?

    Answer: No, there is no automatic conversion from ACT to CS-Team. A provider should have a back-up plan to provide coverage during a team member's absence. All services provided must be on the ITP.

71. Is it correct that a hospital cannot bill for an ACT client who has a psychotic break, and winds up incoherent, but is treated in the ER?

    Answer: That is not correct.

72. How are psychotropic medication services reported under ACT?

    Answer: Services are billed using the ACT activity code for ACT Team members who provide the medication services. It is not billable by staff who are not on the ACT Team.

73. If no one on the ACT Team speaks Cantonese, can an ACT consumer, who speaks Cantonese only, receive 1:1 treatment with a Cantonese-speaking counselor at another agency?

    Answer: Oral interpretation can be billed in collaboration with the provision of another Rule 132 service which includes ACT.

74. May an ACT client receive any other service(s), and if so, which?

    Answer: The ACT Team is expected to provide the full array of services.

75. Can a client receiving Individual Therapy through adult counseling services also receive services from the ACT program?

    Answer: No, the full array of services must be provided by the ACT team.

76. We provide Crisis service in two counties. When an ACT client shows up and the team is not close by, we must provide crisis services. Why will we be penalized by non-reimbursement?

    Answer: You will be reimbursed for crisis services. The expectation is that the client will be referred to their ACT team for follow-up and continuing services.

77. Must ACT staff be dedicated solely to providing ACT services or can those staff also deliver CST services?

    Answer: ACT staff must be solely dedicated to the ACT team on which they are serving (with the exception of the psychiatrist) and therefore cannot serve on both ACT and CST staffing.

78. What are the eligibility criteria for client admission to an ACT Team?

    Answer: Preauthorization by DMH.

79. Can a non-ACT nurse who works for an ACT-Team psychiatrist bill for 25-Med Adm, 26 Med Mgt, etc.?

    Answer: Yes, except to an ACT client. Only ACT team members may provide services to ACT clients and all services will be billed as ACT.

80. How will DMH know that a team is in compliance?

    Answer: Initially when the team is certified and in post-payment reviews thereafter.

81. Is there a restriction on ACT group services?

    Answer: Yes. No more than two hours of group ACT services per week.

82. Please clarify the staff to client ratio for ACT?

    Answer: 60 is the maximum number of clients for a team of 6 staff. There may be fewer clients depending on the acuity of the client.

83. Does the 31 day limit for replacement of ACT team members include the psychiatrist?

    Answer: Yes.

84. Must both ACT and CS-Team clients be initially authorized?

    Answer: Consumers identified for ACT and CST must have prior authorization.

85. Can PSR/ACT be used with the C&A populations?

    Answer: PSR and ACT service definitions are written for consumers 18 years of age and older.

86. Can PSR services be delivered in conjunction with ACT?

    Answer: Consumers cannot receive both ACT and PSR except during authorized periods of transition to or from ACT.

87. How will the Department determine if the psychiatrist was on duty 24/7?

    Answer: The ACT psychiatrist is not required to be on duty 24/7, He/she must provide services 10hrs/week for every 60 clients served in ACT. Determination of compliance will be done through review of agency documentation.

88. What kind of specialized training & certification in substance abuse and/or MISA treatment is required for an ACT team member? Has IDHS identified any training, course work or other ways to acquire that expertise in a way that would satisfy the requirement?

    Answer: The requirement is for training, experience or certification in co-occurring disorders. Documentation of training, experience or certification in the staff record will satisfy the requirement. The agency may establish its own training program, use one already established, look for previous work experience or require certification.

89. We are preparing to form an ACT team and are reviewing rule 132 to make sure we have a good understanding of all the billing/documentation requirements. Should the ACT team bill MHA and treatment planning for assessment and treatment planning activities done with a prospective ACT client prior to ACT authorization? Can the ACT team leader also be the team member with special training and certification in substance abuse treatment?

    Answer: Yes, the ACT team should bill for other 132 services until your agency is certified to provide ACT and the client is authorized for ACT. Yes, the ACT team leader may be the team member with special training and certification in substance abuse treatment. (3/1/12)

90. We have never done any ACT groups but might be starting one. I understand ACT is a bundled service but since there is a different modifier for ACT group, my question is do we need to ACT Group in a Treatment Plan. Or, when ACT is prescribed in a plan, can you provide both individual and group with them each being specified in the plan?

    Answer: Both must be indicated on the plan. (6/1/12)

91. When an ACT staff does a LOCUS, should they bill ACT (since it is all-inclusive) or CM LOCUS (since it is event based)?

    Answer: Bill ACT. (9/1/12)

92. Does the CRSS have to work full time on the ACT team?

    Answer: The rule says that the team must have 6 FTEs. It also says that the team leader, nurse, and four other staff will be full time. Then it says that one of the team members will be a CRSS. It doesn't say that there can't be more than 6 FTEs on the ACT team. However, if the team has only six team members, then the CRSS must be one of the full time team members. Whether full or part time, the CRSS must be an active team member. (9/1/12)

93. Is it acceptable to have two psychiatrists on one ACT team? For instance, if we serve 40 people in ACT, could one psychiatrist have a caseload of 20 and another psychiatrist have a caseload of the other 20?

    Answer: No, it is not acceptable to have two psychiatrists for one ACT team. When the number of clients served by the ACT team exceeds 60 and another 10 per week of psychiatric time must be added, that 10 hours could be covered by another psychiatrist, but even then, both would have to be available a full 10 hours each week. Clients served by an ACT team are, according to Rule requirements, in need of intensive, team-based services. They are not reasonably served by having the psychiatrist only available to them every other week. (12/1/12)

94. Rule 132 requires four staffing per week in ACT. Can we bill for client discussions during these times?

    Answer: ACT teams are expected to hold staff meetings at least four times per week. Time spent in staff meetings was considered in the formula for calculating the ACT rate and therefore, is not separately billable. (3/1/13)

95. If the core ACT team is complete, can an additional team member be added to the team that is not an FTE?

    Answer: Additional team members may be part time. However, they must attend all team meetings. Additionally, the psychiatrist is a core team member and would be expected to function as one. (3/1/13)

96. The changes to Rule 132 in December 2012 to CST seem to limit a provider's use of recovering staff when providing services. Is this true?

    Answer: Existing team members in recovery must be CRSS/CFPP certified by Feb. 1, 2014 and any new team member in recovery must be certified within 12 months of hire. This change was made at the request of consumers and recovery support professionals. The certified staff are recognized as MHPs and can then be used to provide any service allowed to be provided by an MHP. (3/1/13)

97. 1. 2. We are reviewing procedures for ACT and have a question about frequency of treatment plan review. Is the minimum review requirement 90 days?

    Answer: Because ACT teams are at times working with individuals who are new to their agency, and since DMH authorized team services (ACT and CST) require authorization from the start of the service, it was necessary to design the authorization protocols to cover situations where the full assessment and treatment planning process may not yet have occurred. If at the time an initial ACT authorization is needed, the provider has not yet had the opportunity to complete the full ACT assessment and treatment plan, then there is an initial authorization for up to 90 days, at which time the agency must seek a concurrent authorization. It is expected that by the time, the agency will have completed all assessment and treatment plan documentation. This subsequent concurrent authorization can be granted for up to 1 year. So, it is not actually a 90

day review of the treatment plan, but rather the completion of the treatment plan that had not yet occurred at the time of the initial authorization. (6/1/13)

98. If a peer specialist, who is also a Q and vocational specialist, provides a variety of interventions would she/he note those separate interventions in her content or just that she is the peer specialist? We are trying to track intervention types under our ACT billing code to make sure we are staying within the rule.

    Answer: All Rule 132 ACT services are reported/billed as ACT. There are no separate codes for the different example activities that encompass Rule 132 ACT. The documentation must follow Rule 132 requirements and be for each delivery of ACT. (6/1/13)

99. What is meant by environmental supports?

    Answer: Family, landlords, friends, faith-based organizations, community resources, etc. (6/1/13)

100. According to the fidelity scale for ACT, we're not to have more than 10 clients per case manager. I only have four case managers. What is the requirement?

    Answer: In order to be certified to provide ACT, a provider must have six, not four, full time clinicians, plus a psychiatrist and an administrative assistant. The team leader and the RN are both expected to function as full-time clinicians. The team is expected to function as a team, not as a group of individual clinicians with caseloads. Therefore, the ratio is calculated based on the number of people served by the team and the number of full-time clinicians working on the team. (6/1/13)

101. How do we bill when an ACT client goes into crisis residential?

    Answer: When someone has been authorized for and is in ACT and needs crisis residential services, the ACT provider must go to the Collaborative website and complete a transition authorization form. This allow both the ACT and crisis residential providers to bill for services for a 30 day period. (9/1/13)

102. Can an RN fill the role of "licensed QMHP" program leader/manager for an ACT team? If yes, can they also be the team's nurse?

    Answer: An RN is licensed and a Q, so yes, can be the team leader. However, the RN is a full-time position, as is the team leader. Therefore, one person cannot do both. (9/1/13)

103. We have an ACT program managing on-call for their own clients. We would like to know if the assigned ACT staff is unable to cover on-call due to illness or vacation, etc. and no other team member can cover, can we have another clinician cover on-call for the ACT program?

    Answer: Please note that ACT is provided as a team and not as a group of people each with their own set of clients. Each team member should have some familiarity with all clients served by the team and should be able to provide on-call, vacation and sick time coverage. Each ACT team should have a plan for 24/7 coverage that provides for team member vacations and emergency back-up. It should be rare that this plan will not provide for needed coverage. In those rare and temporary situations, a temporary team member may be used. That person must function for that period of time as a full team member by attending team meetings and assuring that all documentation is shared with other team members. (3/1/14)

104. Two ACT staff (neither a supervisor) are discussing a client's treatment with the client present. Is this billable by one of them as ACT?

    Answer: If an intervention as described in Rule 132 is provided for at least the minimum period of time required to bill one unit, then that intervention/service may be billed as ACT for individuals authorized to receive ACT. However, we would expect that most such discussions

would take place during the required 4 team meetings held each week. Team meetings are not billable. (6/1/14)

105. Does the ACT model allow for us to use interns part-time during their practicum time as members of the ACT team?

Answer: There is not a problem with interns/students working with ACT teams. In fact, it is something we have been trying to encourage for workforce development reasons. However, they must qualify as a team member and may only bill at the rate equivalent to the current level of qualifications. Additionally, there must still be a fully constituted team which includes the six full time staff. (6/1/14)

106. Is it acceptable to take a group of ACT clients shopping as long as we document interventions done with each and only bill for the specific intervention time?

Answer: While it isn't recovery focused to take a group of clients served anywhere together, nor to think that their socializing with one another is positive, there is nothing in rule that prohibits this. (6/1/14)

107. Can a Rule 132 provider get approved/certified to provide ACT services prior to having the full team hired?

Answer: No, all required team members must be in place/hired before the provider may be certified to provide ACT. (9/1/14)

108. Rule 132 says that the ACT team must have a core team member that has special training and certification in substance abuse treatment and/or treating clients with co-occurring mental health and substance abuse. What specifically are the training and certification requirements for this person?

Answer: There are no specific training or certification requirements. It's up to the provider to determine and document that the person in this position has training or certification appropriate to treat the population. (9/1/14)

109. Can the team leader of ACT with approved accommodations provide ACT services only on-site during regular business hours as long as the rest of the team is in the community and is able to cover the on-call and crisis needs?

Answer: There is nothing in Rule 132 that requires any particular team member to be in the field. However, per Rule 132 75% of all ACT services must be provided in natural settings. Additionally, the team leader must serve as the clinical and administrative supervisor of the team and function as a clinician. If this person can do that without being in the field, and the lack of field time by this person doesn't affect the team's ability to provide 75% of ACT in natural settings, then, again, Rule 132 doesn't prohibit it. (3/1/15)

110. Can someone who is working on obtained an RN begin working as the ACT RN prior to actually getting the RN as long as this person isn't giving injections?

Answer: No, the RN on the ACT team must be an RN. (3/1/15)

111. Can a provider bill ACT for an individual who is transitioning to ACT, but is not yet authorized for ACT? If the transition services are provided by ACT staff, can those staff bill ACT?

Answer: Until an individual is authorized for ACT, a provider may not bill services provided as ACT.

112. Can an ACT team provide services to clients who are dual eligible (Medicare/Medicaid)?

Answer: Someone who is dually eligible (Medicare/Medicaid) may receive ACT services. The ACT

service would have to be medically necessary and authorized by DMH through The Collaborative. Additionally, coordination of benefits would have to be done with billing to Medicare first because Medicaid is the payer of last resort. (3/1/15)

113. For MCO members receiving ACT services where the MCO requires authorization of those services, are we required to send an ACT authorization packet to the Illinois Mental Health Collaborative? Also, for a participant authorized and in crisis, do we bill under ACT service code or crisis intervention service code?

Answer: For MCO members you get authorization only from the MCO. The individual still needs to be registered with the Collaborative, but the Collaborative doesn't do any authorization. For someone not covered by an MCO and Authorized for ACT, all services provided should be provided by the ACT team and billed as ACT. (9/1/15)