Virginia Medicaid: Project BRAVO Services FAQs

Topic	Question	Response
Assertive Community Treatment (ACT)	**30 calendar day Individual Service Plan (ISP) Review/update:** What documentation do we require? What information has to be included? Does the individual have to sign it? How does it fit with the 90-day review requirements?	Please see Mental Health Services Manual, Chapter 4, starting on page 21 for information related to ISP reviews and requirements. The same requirements apply to 30-calendar day ISP reviews/updates, as would a 90-calendar day review or any ISP review that is determined to be needed based on an individual's circumstances/treatment progress. A 30-calendar day ISP review can replace the 90-day calendar ISP review during the month that the 90-day calendar ISP review is due. DMAS will be updating the language in the Mental Health Services Manual, Appendix D, Intensive Community Based Support to clarify the requirement. These changes will be posted when the manual is updated December 2021 for Phase #2 of Project BRAVO.
Assertive Community Treatment	**Covered Services:** Does an ACT team have to provide all crisis intervention/treatment to the individuals that the team services?	The ACT team is responsible for providing crisis intervention/treatment for the individuals they serve. Department of Medical Assistance Services (DMAS) has provided for the allowance of Crisis Intervention (H0036)* or the purposes of, in the rare instance that the ACT team is unaware of a crisis situation, the individual is in the community and a Community Services Board (CSB) is contacted to provide Crisis Intervention for the purposes of an Emergency Custody Order/Temporary Detention Order assessment. *The Crisis Intervention code and service requirements are changing 12/1/2021 and additional guidance will be given in the 12/1/2021 update of the Mental Health Services Manual

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Assertive Community Treatment	**Service Limitations:** Occasionally, an individual receiving ACT services temporarily needs a higher level of care. In order to divert them from hospitalization, they may be admitted to our residential care unit for Crisis Stabilization or ASAM 3.5/3.7 services. Since we would not be billing ACT services during that time, would we be permitted to bill Crisis Stabilization or ASAM 3.5/3.7 services even though the client will remain open with ACT and will resume ACT services after discharge from the residential unit?	Please see Mental Health Services Manual, Appendix D, page 7. ACT may not be authorized concurrently with Individual, Group or Family Therapy, Addiction and Recovery Treatment Services (ARTS) and Mental Health (MH) Intensive Outpatient, Outpatient Medication Management, Therapeutic Day Treatment, Intensive In Home Services, Crisis Stabilization, Mental Health Skill Building, Psychiatric Residential Treatment Facility (PRTF), Therapeutic Group Home (TGH), ARTS Level 3.3-3.7 or Peer Recovery Support Services, as the activities of these services are included in the per diem. Limited service authorization overlap with these services is allowed as individuals are being transitioned from ACT to other behavioral health services (see service authorization section). Office based opioid treatment services (OBOT) and Office Based Addiction Treatment (OBAT) services are allowed simultaneously with ACT. Individuals receiving ACT can receive Crisis Intervention (H0036) or Mental Health Partial Hospitalization (H0035) and do not need to be discharged from ACT, all other services above, a member must be discharged from ACT to be able to receive a service authorization for the services, unless during the planned 31 day discharge period where overlap can occur if communication with the member's MCO/BHSA occurs. Additional guidance for ACT service limitations will be given in the 12/1/2021 update of the Mental Health Services Manual when the new crisis services are implemented.

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Assertive Community Treatment	**Service Authorizations:** Would you please confirm that service reauthorization requests for ACT services are required annually? Is there any supportive documentation (such as an assessment or an ISP) that is required to be submitted with the Service Request Authorization (SRA)?	The authorization timeframe and approved units are based on medical necessity and the clinical need of the individual. Initial Requests: The service request authorization form was designed to cover the majority of what would be captured in the assessment and initial ISP on the form itself, however, a health plan could ask for this information if they needed additional information to determine MNC. Continued Stay Requests: Supporting documentation must be submitted to include the ISP, the service specific assessment or Comprehensive Needs Assessment, and any addendums to the assessment with the service request authorization. Forms can be found here: https://www.dmas.virginia.gov/for-providers/behavioral-health/training-and-resources/
Assertive Community Treatment	**Assessments:** If the psychiatrist is requesting to also complete a psychiatric evaluation along with the comprehensive assessment for new clients, will we be able to bill the psychiatric evaluation as H0040, if the 90791 code has been billed?	All covered ACT services should be billed using H0040 and the appropriate modifier. This scenario would all be considered covered ACT services and must be billed using H0040. The 90791 can only be billed if the individual does not meet the MNC for ACT in order for a provider to be reimbursed for the assessment; otherwise, the comprehensive needs assessment and the psychiatric evaluation are billed as H0040 with modifier as covered ACT services.
Assertive Community Treatment	Assessments: Can we bill both a comprehensive needs assessment and psychiatric evaluation with H0040 and modifier?	Yes, you would bill both services as covered ACT services and receive the per diem as long as the services were provided face-to-face and lasted a minimum of 15 minutes. Only one per diem can be billed per day. More information can be found in the Intensive Community Based Support, Appendix D, starting on page 17.

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Assertive Community Treatment	If an LMHP completes a Comprehensive Needs Assessment (CNA) on the first day of services and the psychiatrist completes their assessment within that first week of service, can the per diem be billed from that first date with the LMHP? What intervals are required for assessments?	DMAS encourages same day scheduling and acknowledges that it is not always possible to do both in same day. If the assessments cannot occur on the same day, submit the service authorization after both assessments are completed and indicate both dates. Request the start date be retroactive to the day the first assessment was completed. Please see Mental Health Services Manual, Chapter IV, page 19. Assessments are required prior to the initiation of services and reviewed/updated annually.
Assertive Community Treatment	**Service Requirements:** Does care coordination have to occur face-to-face?	Care coordination does not have to be completed face-to-face, however, in order to bill the per diem, a fifteen-minute face-to-face covered service is required. If care coordination is the only covered service provided and it is not provided face to face, providers cannot bill the per diem that day. In addition, telehealth (synchronous audio/visual) is considered face-to-face, and as a result, care coordination that is completed via telehealth is counted as part of the 15-minute face-to-face requirement in order to bill the per diem.
Assertive Community Treatment	**Telehealth:** Is telehealth a viable option for ACT services?	Yes, telehealth is a viable option for ACT services when deemed appropriate to meet the needs of the individual.

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Mental Health Intensive Outpatient	**Accreditation**	Mental Health Services Manual, Appendix E, page 9: MH-IOP service providers shall be accredited by Commission on Accreditation of Rehabilitation Facilities (CARF), Council on Accreditation (COA) or Joint Commission, licensed by the Department of Behavioral Health and Developmental Services (DBHDS) as a provider of Mental Health Intensive Outpatient Services, and 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. For newly DBHDS licensed providers, documentation from the accrediting body that accreditation has been initiated must be submitted to the MCO or FFS Contractor. Full accreditation must be completed within two years of the date on the documentation submitted.
Mental Health Partial Hospitalization Program	**Medicare Certification**	Mental Health Services Manual Appendix E, page 24: MH-PHP service providers shall be licensed by DBHDS, as a provider of a Mental Health Partial Hospitalization Program, be Medicare certified as a partial hospitalization program and credentialed with the individual's Medicaid Managed Care Organization for individuals enrolled in Medicaid managed care or the Fee for Service (FFS) contractor for individuals in FFS. MH-PHP service providers must follow all general Medicaid provider requirements specified in Chapter II of this manual. Providers have a year from the date they become contracted in the MCO network or FFS Contractor as a MH-PHP provider to become Medicare certified. Please see guidance document under Resource Section here: https://www.dmas.virginia.gov/for-providers/behavioral-health/enhancements/