

5.5 Mobile Treatment Services (MTS)/Assertive Community Treatment (ACT)

Service Coverage

Mobile Treatment Services are community-based, intensive, outpatient services rendered by providers approved under Maryland Law (COMAR 10.21.19). Mobile Treatment Services provide assertive outreach, treatment and support to individuals with mental illness who may be homeless, or for whom more traditional forms of outpatient treatment have been ineffective. Service is provided by a multidisciplinary team, is mobile and is provided in the individual's natural environment (e.g., home, street, shelters). Mobile Treatment Services also are available for children, adolescents and their families who require more intensive intervention in order to clinically stabilize the child's or adolescent's psychiatric condition, to promote family preservation and/or to return functioning and quality of life to previously established levels as soon as possible.

Services provided include psychiatric evaluation and treatment, clinical assessment, medication management/monitoring, interactive therapies, support with daily living skills, assistance with locating housing, and case management. The duration, frequency and intensity of services provided are determined by an individual's treatment plan. The goals are to connect consumers to treatment services in the community, avert hospitalizations, and remediate tenuous living situations.

Service Rules

Mobile Treatment Services (MTS) are paid through a monthly rate that is reimbursed through Medicaid or with state general funds. The expectation is that consumers will be seen, at a minimum, for four face to face contacts in a month. The four visits is a minimum requirement with the expectation that additional contacts will be provided as needed. Since MTS targets individuals who previously have not engaged in mental health treatment, services are expected to be delivered in community settings. Office visits may be counted under certain circumstances such as Co-occurring Groups, etc.

Mobile Treatment Services/ACT is authorized in monthly blocks. Regardless of when in the month a request for Mobile Treatment Services is authorized, the first day of the month is used as the beginning date of authorized service. For example, if the service begins mid-month, the provider will receive payment for the full month.

The MTS provides outreach to individuals to facilitate the individual's acceptance of services and treatment. Occasionally, the MTS team goes to meet with an individual and the individual is not at home or may refuse to see the team. In these instances MHA has said that the program may count the attempted visits toward

the four visits required per month. The MTS is to document in the medical record the unsuccessful outreach attempts to see the consumer. When individuals are hospitalized for brief periods of time, MTS may see the individual in the hospital but may not count the visit towards the required 4 encounters. The minimum 4 encounters are to be provided only on separate days. If a MTS team sees an individual in the morning and again in the afternoon, only one encounter per day may be counted.

Based on the needs of the individual, a one month overlap of services may be appropriate in order to transition the individual to more traditional mental health services, e.g. transitioning from Mobile Treatment to OMHC. In some instances a longer transition period may be necessary

Permission to treat a minor is required from the legal guardian. Adolescents age 16 and over may consent to treatment for themselves.

ValueOptions[®] Maryland will contact the ACT provider when an individual served on an ACT team is hospitalized for the purpose of discharge planning and service coordination

The mental health service provider is expected to exchange information and coordinate care with the consumer's primary care physician and other treatment providers (e.g.. substance abuse treatment) when clinically appropriate.

Service Eligibility

Consumers with MA, PMHS-eligible Medicare recipients, and Uninsured Eligible consumers (see Chapter 3) are eligible for Mobile Treatment Services.

Service Providers

Mobile Treatment Services are provided by agencies approved under Maryland Law (COMAR10.21.19) by the Department of Health and Mental Hygiene (DHMH).

A Mobile Treatment Service is eligible to receive evidence-based practice rates of reimbursement after meeting the requirements outlined in the MHA Memorandum entitled "Assertive Community Treatment (ACT) – Evidenced-Based Practice (EBP) Project including meeting the required scores to be considered an EBP ACT program

All providers must have an active Maryland MA provider number and a signed provider agreement with DHMH.

Authorization Process

To obtain initial authorization for Mobile Treatment Services/ACT, the provider must submit a pre-authorization request through ProviderConnect. If medical necessity criteria are met, Mobile Treatment Services will be authorized by ValueOptions[®] Maryland (*usually in six month increments*).

Providers obtain additional authorizations through the submission of a Continuing Review Authorization Request. (see ProviderConnect Users Guide for directions on completing an authorization request). The provider must submit a Continuing Review Authorization Request prior to the expiration of the previous authorization time span.

If a ValueOptions[®] Maryland Care Manager is unable to authorize the service as medically necessary, the request for services will be referred to a ValueOptions[®] Maryland Physician Advisor for review. The determination will be communicated via ProviderConnect to the provider. (See Chapter 9, Grievance and Appeals.)

Claims Process

Only one monthly fee is reimbursable. Providers should bill with the first date of service the consumer was seen using a CMS 1500 form (see Chapter 16 for directions). Claims may not be submitted for the monthly fee until the calendar month has ended.

Claims must specify an ICD-9 code (not DSM IV-TR code) for reimbursement.

In rare circumstances, Mobile Treatment services may be authorized for individuals with complex and unique needs who may also be receiving PRP and/or Case Management Services.

Claims for unauthorized services will be denied.

Problems and Solutions

If the services requested do not meet Medical Necessity Criteria and care is non-authorized, please refer to Chapter 9, Grievances and Appeals.

Authorizations can expire because the authorized time frame for services has ended. To ensure reimbursement for services, if additional services are needed beyond the time frame originally authorized by ValueOptions[®] Maryland, the provider must submit to ValueOptions[®] Maryland a Continuing Review Authorization Request for services. This Authorization Request must be submitted prior to the end of the current authorization time span. (See ProviderConnect Users Guide for directions for completing Authorization Requests.)

It is necessary to notify ValueOptions[®] Maryland if it is anticipated that a consumer will be discharged prior to the end of the authorized time span. (See ProviderConnect Users Guide for directions on how to discharge a patient.)

Does an office visit count as a face to face encounter?

Answer: MTS are expected to be in the community.

If an intake is conducted mid month and the person is seen for services in the first month a couple of times, is that person's service billable?

Answer: Yes a minimum of two face to face contacts have been made and this is documented. This applies only to the intake month.

What if an intake is completed the last week of the month can the agency bill?

Answer: Yes a minimum of two face to face contacts have been made and this is documented

If a person is seen three times then disappears and a worker goes to the home a couple of times without success as well as making calls etc., can this be billed?

Answer: Yes as long as efforts to make contact are documented

When a person enters a hospital or jail for a period of time under 30 days and MTS visits the person in the institution to provide support, linkage, and discharge planning, and the person is released in under 30 days, with four face-to-face contacts, can we bill for the month?

Answer: If the person is in the hospital or jail for less than 15 days that month and the MTS visits the person to maintain continuity of care it may count the visits towards the minimum four provided the MTS makes at least 2 face to face visits in the community.

If a person decides to leave services mid month and proper discharge planning occurs, is that month a billable month?

Answer: Yes as long as least two visits were provided.

May a MTS program see more than one family member?

Answer: Yes, as long as each family member meets medical necessity criteria for the service and the MTS provides a separate and distinct intervention for each family member. Separate medical records should be maintained, and the contact properly documented.

May two family members be seen by the same team member at the same time?

Answer: Yes, however, this would be seen as rare. Separate medical records should be maintained, and the contact properly documented in each consumer's record.