ACT Diamond Build and Claims Considerations

(Draft 7/06/06, subject to change)

Service Tracking in MACSIS

- Procedure codes for ACT are H0040 for the clinical component and M1910 for the non-clinical component. Medical Definitions are 1850/2850 for clinical component and 2855 for non-clinical component.
- Use Modifier 1 = HE to bill for both procedure codes. Modifier 2 can only be blank or 99. Modifiers 3 and 4 can be used if desired.
- Billing unit is per diem (one a day) for the purposes of determining the rate.
- One claim for each day in the month (for each service), with one unit per claim, billed to MACSIS at the end of the month. Thus, for a month with 31 days, 62 claims should be submitted.
- Rates for both H0040 (the clinical component) and M1910 (the non-clinical component) should be entered on PROCP records using the alternate price schedule (begins with the letter A). When CMS/ODJFS approval to bill Medicaid occurs, Medicaid staff will enter a new PROCP and rate with the primary price schedule for H0040. At that time, Boards will need to enter a termination date on the PROCP for H0040 with the alternate price schedule and also enter a new PROCP with the primary price schedule if a local price region is used for non-Medicaid clients.
- Boards are responsible for knowing if a provider has been certified to provide ACT, and the start date of the PROCP should have the certification date as the start date.
- Clients can receive both clinical and non-clinical components each period, or just one or the other. There is no requirement that both must be provided in the same billing time period.
- No partial units can be billed (will receive an invalid medical definition).
- Clients cannot receive both ACT and IHBT on the same day (benefit rule will deny the second claim).
- Clients in the Cuyahoga Medicaid waiver program are ineligible for ACT.
- If the place of service on the claim is 51 (IMD or state hospital) and the client is between the ages of 22 and 64, the claim will not be billed to Medicaid.
- Primary diagnosis for clinical component must be one of currently approved Medicaid codes (not just the ones listed in the ACT rule). No diagnosis is required on claims for the non-clinical component.
- If the minimum number of required services is not met during the month, the provider CANNOT bill for unbundled services.