Comments for Chapters 502 and 503

Effective Date July 1, 2014

Date Comment Received	Comment	Status Result C=Change NC=No Change D=Duplicate	Action for Change Status	Reasoning for No Change Status and FAQ's
4/29/14	In section 503.16.2 – Mental Health Service Plan Development by Psychologist (H0032 AH) – the "TELEHEALTH" availability has been omitted. Can this procedure by provided via telehealth by a Psychologist?	C	Put Available on H0032AH for Tele-health in Chapters 502 and 503	
4/29/14	503.3, page 5, Medical Necessity APS UM guidelines cite the Managed Care position paper published in 1999 by the State of WV. This defines medical necessity as: "Services and supplies that are: ▪ (1) appropriate and necessary for the symptoms, diagnosis or treatment of an illness;	C	Added in Chapters 502 and 503. Put on pg. 5 Listing of Medical Necessity We are matching the position paper and the UM Guidelines	.

	▪ (2) provided for the diagnosis or direct care of an illness; ▪ (3) within the standards of good practice; ▪ (4) not primarily for the convenience of the plan member or provider; and ▪ (5) the most appropriate level of care that can be safely provided.”			
5/6/14	I would suggest including the definition of Medical Necessity under 503.3 in the manual to make it more consistent with the managed care position paper published in 1999 in which the state defined Medical Necessity as: Services and supplies that are: 1.) appropriate and necessary for the symptoms, diagnosis or treatment of an illness; 2.) provided for the diagnosis or direct care of an illness; 3.) within the standards of good practice; 4.) not primarily for the	D		

	convenience of the plan member or provider; and 5.) the most appropriate level of care that can safely be provided.			
5/6/14	The definition for Psychological Testing with Interpretation and report suggests that the report could have a mental status exam or a social history through the inclusion of the "and/or". This could result in some psychologists not performing a mental status exam and documenting it in the report and stating they were still meeting service definition. Suggestion: Indicate that a mental status must be performed. And indicate that the report "may include" a social history. The documentation requirements stated in the manual do specify that a mental status exam must be documented, but this appears inconsistent with the definition as currently written.	C	Added “This service should not be used for interpretation and report of technician and computer administered tests” This language was taken directly from the 2014 CPT Manual Changes were made to Chapters 502 and 503	.

5/6/14	The documentation requirements state merely that the presenting problem must be documented. This is inconsistent with the other Assessment/Testing services that indicate a "purpose of the evaluation" must be documented. SUGGESTION: Make this code consistent with the other Assessment and Testing codes by including the documentation requirement for the "purpose of the evaluation	C	Added “Purpose of Evaluation” on all documentation pertaining to assessment and testing codes. Language consistency across all evaluation and assessment codes in Chapters 502 and 503.	
5/6/14	Under the Service Description of the Individual and Group Supportive sections of the manual 503.17.3 and 503.17.4 it states under #2 "the interventions will assist the individual as he or she explores newly developing skills..." Suggestion: I would suggested changing "newly developing skills" to "*newly acquired skills*."	NC		BMS does not believe the word “acquired” needs to be added to r this service definition.
5/7/14	Put psychologist in 503.7 pg. 8 Add Psychologist	C	Psychologist was added to Chapter 503	

5/9/14	The requirements for the Master Plan are: "Date of development of the plan, participants in the development of the plan, a statement or statements of the goal(s) of services in general terms, a listing of specific objectives that the service providers and the member hope to achieve or complete, the measures to be used in tracking progress toward achievement of an objective, the techniques/services to be used in achieving the objective, individuals responsible for implementing the services, a date for review, start and stop times and credentials." The additional statement, "In general, it is expected that objectives be specific, measurable, realistic and capable of being achieved in the time available..." .	C	Removed the term “In General” from throughout Chapter 502 and 503	
5/7/14	Additionally, requirements concerning Discharge Planning are omitted	C	Added to Chapters 502 and 503	

5/7/14	ACT- PG 54 ACT Team must meet daily except for federally recognized holidays and also stated that way on pg. 55 but under documentation requirements on pg. 58 it states a log must be documented except weekends and federally recognized holidays. and	C	Removed “Weekends”- ACT which is a nationally recognized evidenced based model indicates that weekends should be included.	
5/7/14	ACT-I also was wondering about the 2 hour face to face requirement	C	2 contacts (no duration of time required) in Chapter 503	
5/7/14	ACT-the urban/rural numbers 120 until the rural fidelity factors released	C	120 Max per ACT Team added to Chapter 503	

5/7/14	In the rehabilitation manual under program requirements for program supervisor, it states that a bachelor's level in a human service field with at least one year of experience providing services to individuals with mental retardation and/or developmental disabilities. Is that accurate for rehabilitation programs for persons of mental illness? The next section stating staff with a Bachelor's degree that does not have experience must meet one of the three following: completion of specific courses relating to developmental disabilities…is this accurate or education specific to the targeted population?	C	"Education specific to the targeted population" being treated added to Chapter 502 and 503.	
5/7/14	On page 2 contents: Should read the screening by Licensed Psychologist (Same in Both Manuals)	C	Corrected Licensed Psychologist in Chapters 502 and 503	
5/7/14	Both manuals have excluded treatment of Alcohol Dependence by Vivitrol under the Non-Methadone Policy. Alcohol dependence should be included throughout the entire policy or an explanation given. Also, I think there are different requirements for Vivitrol as to who can prescribe that may need to be added.	C	Clarified Vivitrol standards in Chapters 502 and 503	

5/9/14	Remove " in general" from any areas of the Clinic and Rehab Manuals	D		
5/12/14	Section 503.7 indicates that a physician or physician extender must certify the need for BH Rehabilitation Coordinated Services by signing the BH Clinic/Rehab Form Add Psychologist/Supervised Psychologist	D		
5/12/14	Section 503.5 Change to read "All rehabilitation provider staff, having direct contact with members must, at a minimum have results from state level Fingerprint Based Background Check. The check must be conducted.	NC		BMS is streamlining services and programs to match one another concerning Criminal Background Checks. We have several providers in addition to being BH Providers are Waiver providers through BMS and allow a 90 day window for receipt of results.
5/12/14	The Clinic Manual indicated that if a member is in focused services the 72 hour Authorization for Services Form is required.	C	This section was pulled from Chapter 502	
5/12/14	On pg. 5 it would be beneficial to include the 5 criteria of Medical Necessity. Many providers indicate that they cannot find those 5 criteria within manuals specifically stated. That would be very helpful to new staff providing WV Medicaid Services	D		

5/12/14	In 503.9 it indicates that the provider will receive a report within "30 days" is this 30 business days or calendar days? There is a difference to both the ASO reviewer as well as the provider	C	Clarified Business Days in Chapter 502 and 503	
5/12/14	For psychological testing (page 17-18 within 503.15.2) the definition talks about "integrating technician and computer administration…". Below are some comments related to this. 1. There is nothing within the section that specifically indicates that psychometrician work (i.e. individuals without a Gold Card from the WV Board of Examiners) is not reimbursable. Listing a section that contains un-reimbursable activities would be greatly beneficial. These would include things such as: a. Psychometrician administration, scoring, etc. is not reimbursable. a. Self-administered assessments in which the client	C	Added Service Exclusions to Chapter 502 and 503 Reinforcing the psychologist for face to face. 1.Psychometrician/Technician Work 2. Computer-Scoring 3.Self-Administered Assessments 4. Computer-Interpretation The above addition is in the 2014 CPT Code manual and was added to the manuals for clarification.	

	answers question items on their own or on a computer does not involve the psychologist administering any assessment and is not reimbursable. b. Computer scoring. Does not require a credential of a licensed psychologist to enter scores into a computer and is generally considered administrative in nature and is not reimbursable. 2. Utilizing computer interpretations without dramatic synthesis and changing of the computer generated interpretation does not demonstrate that the psychologist conducted the interpretation. If the report demonstrates that a computer generated interpretation was utilized, interpretation time should not be reimbursable. Report writing/report formulation.			

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5/12/14	For Supportive counseling, page 29, below is a comment related to both group and individual supportive counseling. 1. The service limit indicates prior authorization while other services indicate the initial benefit within this section. Seems a little confusing that these 2 services do not have a service limit. For Therapeutic Behavioral Services, below are some comments related to both development as well as implementation.	NC		BMS actively works to ensure that our members are given individualized treatment pertaining to their accessed Medical Needs as such every individual may need a varying levels of units authorized to address this. The ASO prior authorizes units based upon the information they receive from the provider. .

5/12/14	On page 70, clarification related to observation would be beneficial since many providers appear confused as to what that means. For example, observation should occur as a last resort and/or when medical necessity has been demonstrated for staff to go into the home for a period of time to observe the occurrence of a particular maladaptive behavior.	C	Observation was moved to the end of the sentence pertaining to Therapeutic Behavioral Services in Chapter 503	
5/12/14	On page 71, it indicates that …"must develop a maintenance plan". Is this a "*Must"* or is the meaning "*May"* (i.e. "may develop a maintenance plan when medically necessary)? *a.* The way it reads it almost forces staff to develop a plan when one may not be necessary or needed.	C	Added on pg. 71 of Chapter 503 "May develop a maintenance plan when medically necessary" Clarification	

5/12/14	On page 72, under Data Analysis and Review it indicates “direct observation”. The manual does not define when. For example, direct observation when medically necessary. Since the manual indicates “direct observation”, many staff assume that means they can go into the home (or school) and observe for hours and it is reimbursable	NC		FAQ Direct Observation by agency staff should only occur when medically necessary due to behavior theory indicating that observation by individuals not normally within a child’s natural environment changes their normal behavior patterns due to the child being aware they are being observed.
5/12/14	On page 73, under criteria for success. Can it be clarified that the criteria for success needs to be understandable by the client and care givers? Many plans have too complicated criteria for success that the client/client cannot understand.	NC		FAQ Yes, the criteria should be understandable. BMS would like the members and their guardians to participate in their own care as much as possible. BMS plans to create a parent handbook by December 2015 to help members and guardians navigate Medicaid behavioral health services.

5/12/14	On page 75, under Implementation, can it be clarified that recreational activities (i.e. taking the child for ice cream or the park) are not reimbursable? Many plans have the child earning points to eventually earn ice cream or going to the park, etc. Staff are taking the child to get ice cream for 1 ½ hrs and claiming implementation since they are "delivering" the reinforce	NC		FAQ No. Recreational activities are not reimbursable.
5/12/14	On page 75 under, Implementation, there is no documentation within the manuals related to movement of implementation moving toward those within the client's natural environment conducting the implementation of the plan. It would be greatly beneficial to have that clarified since often times agency staff are providing implementation of plans for extended (i.e. 9-12 months) periods of time.	NC		FAQ Yes. The member's guardians, teachers, or other supports should take over the responsibility for implementation of the behavior management plan. BMS plans to create a parent handbook in 2015 to help members their families and/or guardians navigate this and all Medicaid behavioral health services.

5/12/14	Section 503.8 Additional information governing the surveillance and utilization control program may be found in *Chapter 800 (A), General Administration*, of the Provider Manual and are subject to review state and federal auditors. This sentence does not make much sense. Is it supposed to say that the manual is subject to review?	C	Corrected in Chapters 502 and 503 the following sentence states "Additional information governing the surveillance and utilization control program may be found in Chapter 800 (A) General Administration, of the Provider Manual and are subject to review by state and federal auditors"	
5/12/14	Page 2 503.15.5 Screening by Licensed Psychologist – corrected from Licenses	D		
5/12/14	Page 5 503.36 Medical Necessity Medical necessity should be reviewed and demonstrated periodically or at critical treatment junction – eliminate language that suggests EACH note requires 5 medical necessity elements	NC		BMS will not make a change concerning medical necessity in progress notes. It is expected that progress notes show continued medical necessity for the services that are provided.

5/12/14	Page 6 503.4.2 Enrollment Requirements: Staff Qualifications Suggest changing wording for Physician Assistants who do not have a "collaborative agreement" with a physician but rather have a Board of Medicine approved supervising physician.	C	Wording was changed to "Physician Assistants who do not have a "collaborative agreement" with a physician in Chapter 502 and 503	
5/12/14	Page 8 503.7 Service Certification Requirements Licensed Psychologist has been omitted as an authorized certifying professional.	D		
5/12/14	Page 9 503.9 Rehabilitation Provider Reviews This section is redundant. Plan of Corrections- Reviews by OHFLAC and Contracted Agent	NC		This plan of correction is related to disallowance of services due to misuse or inadequate delivery of services while the OHFLAC plan of Correction is based upon Health and Safety and is not related OHFLAC Plan of Correction in any way..

5/12/14	Page 11 503.11 Other Administrative Requirements • If requested the provider must provide copies of Medicaid members records within 24 hours of the request. Comment – 24 hours – or business hours?	C	Changed to 1 Business Day in Chapters 502 and 503	
5/12/14	Page 14 "Appropriately trained is defined as trained in systematic de-escalation with a job description that involves patient management." Comment – should this be changed to say with documented training in systematic crisis de-escalation and not worded as a job description?	C	Job Description was removed from Chapter 502 and 503	
	Page 14 Many of these requirements are redundant – for example 5th bullet requiring quality assurance and improvement program specific to Telehealth services? And 10th bullet – requiring specific consents for Telehealth. All clients have the right to withdraw from treatment being delivered by ANY method.	NC		Telehealth is a new mode of service delivery and different standards may apply.

5/12/14	Page 21 503.15.6 Developmental Testing Staff credentials include physician and physician extender. Would they perform such service?	NC		The physician and physician extender may perform the service.
5/12/14	Page 24 Licensed psychologist has been omitted from line 5.	C	Licensed Psychologist was added to Chapters 502 and 503	
5/12/14	Page 26 503.16.2 Documentation “IN INK” should be removed to allow for electronic documentation systems.	C	Addition of INK or Electronic Documentation Systems was made to Chapters 502 and 503	

5/12/14	Page 45 503.21.2 Community Psychiatric Supportive Treatment "There must be a minimum of two staff present onsite at all times Community psychiatric supportive treatment is provided, one of which must have a Bachelors level degree or higher in a human service related field." Comment – while I agree there needs to be an LPN or higher degree individual present, the need for a Bachelor's level staff 24/7 seems to be unnecessary and will create a problem for crisis units. It essentially will raise the cost of service provision without any benefit. The presence of a bachelor degree during hours of sleep seems excessive	C	Must be an LPN or higher for 1 staff High school level degree must be trained in systematic descalation and must have training toward targeted population treated in CSU i.e. Substance abuse Mental Health Changed were made to Chapter 503.	

5/15/14	On page 71, the last “paragraph” at the top of the page indicates “Following implementation of the Behavior Management Plan, behavior assessment must occur to determine objectively whether to continue, modify, or terminate the plan.” This is contradictory to page 72 which indicates that Data Analysis and Review is used to determine if the plan is continued, modified, or terminated. Please clarify which component should be utilized once there is a plan developed and is being implemented. Thanks.	NC		Data Analysis and Review is part of completing a Behavioral Assessment so no change is needed.
5/15/14	On page 26 within 503.16.3 (Physician Coordinated Care Oversight Services) it does not indicate that the physician or physician extender needs to include the date of their signature. Is this a requirement? If not how does one determine if they were present when required or signed within the 72-hour time frame? Thanks	C	Added Date of Signature in Chapter 502 and 503	
5/18/14	On page 5 of 8, bullet numbers 4 and 5 have every bullet underneath the header in bold except for the last bullet.	NC		Formatting Issue

	On the table of contents, would you like to list the service codes for each service there as it is in the old manual?			
5/19/14	I want to first express how pleased I am that the BMS has changed the manner that census days are calculated in order to allow residential care to be more family friendly and consistent with the values and principles of the WV System of Care and the Building Bridges Initiative. I am very pleased with the process that allowed both provider and family voices to be heard and to guide the development of the Rehab manual revisions on this matter. This decision will go a very long way in helping us to remove barriers to making out of home care more family driven and youth guided. Please accept my sincere thanks for this decision and resulting revision. My second area of comment is concerning the changes in the credentialing for supportive counseling. This will have a tremendous impact on residential care providers, most especially	C	All new hires as of July1, 2014 must be BA Level in Human Services (See manual for acceptable degrees) . Current staff providing Supportive Counseling must obtain BA Degree by July 1, 2018. Changed in Chapters 502 and 503	

	rural providers as work force and funding is a huge barrier if we are going to continue to be expected to provide supportive counseling in our facilities as we have been required to provide. I do hope providers will have an opportunity to discuss the implications of this change and a path to reaching consensus provided. Thank you for the opportunity for input and comments,			
5/20/14	Page two, definitions: Definition of ACT should include a reference to addictions as co-occurring illness, as well as mild developmental disabilities	C	Added Co-Occurring Mild MR to Chapter 503	
5/20/14	Page two, definitions: Definition of BH Rehabilitation services should include physician extender and supervised psychologist	C	Correction made in Chapter 503	
5/20/13	Page two, definitions: Definition of BH Rehabilitation services should include physician extender and supervised psychologist	NC		See Definitions in Chapter 503
5/20/14	Page 5, 503.3 first paragraph: "Medical necessity must be demonstrated periodically during	D		

	treatment and at each critical treatment juncture".			
5/20/14	Page 5, 503.4.1: Should make allowance for smaller agencies to have a credentialing officer rather than a credentialing committee.	NC		See definition of Internal Credentialing
5/20/14	Page 5, 503.3; First bullet should state "Diagnosis as determined by credentialed professional"	NC		See Chapter 503
5/20/14	Page 6, 503.4.2: Second paragraph first sentence: "A Physician's Assistant must have a supervision agreement registered with the Board of Medicine. An APRN must have a signed collaborative agreement for prescriptive authority with a physician."	D		
	Page 7, 503.5; Can the requirement for background checks each three years be delayed until the fingerprint system is fully operational?	NC		BMS must have policy that meet the federal requirement.
5/20/14	Page 8; 503.5; What is the purpose of required reporting of termination of an employee for change in conviction status to the Program Manager? This is a	NC		BMS is currently developing a system through their federal partnership with a grant through CMS that will require a system to report the termination of an employee due to conviction status.

	personnel matter for the employer to manage.			
	Page 8, 503.7; First sentence should include licensed and/or supervised psychologist. Also, the manual does not include a copy of the revised 72 hour authorization. We would appreciate the opportunity to review…..	D		
5/20/14	Page 9, 503.7: Coordinated Care requires a 72 hour authorization for service; however the initial plan is not required before 7 days, leaving four days of unauthorized service. This is not a change from prior manual but may be problematic nonetheless.	NC		FAQ The 72 hour authorization covers the services provided until the initial service plan is developed. Providers have the option of developing the initial plan within 72 hours, thereby eliminating the need for the 72 hour authorization.
	Page 10, Plan of Correction: This seems burdensome and an invasion of managerial responsibility. From our perspective, potential rollbacks should be sufficient to trigger action by management to prevent future issues	D		

5/20/14	Page 11, 503.11, fifth bullet: We are requesting that this be amended to three working days rather than 24 hours, since it does not take into consideration staffing demands and weekends.	D		
5/20/14	Page 12, Focused care, last sentence in first paragraph: recommend be changed to: “The professional and the member and/or member’s DLR together establish a treatment strategy which is documented in the member’s record. The treatment strategy guides treatment and is reflected in the progress note. It may consist of one or more of the following Medicaid services:”	NC		FAQ BMS does not require a specific tool to be utilized.
5/20/14	Page 13, 503.12: Question: Is Clozaril Case Management provided only in combination with medication management considered to be a focused service? We recommend that this be the case.	NC		FAQ Yes, it may be provided as a focused service.

5/20/14	Page 14, 5th bullet: Because this requirement duplicates the requirement that an agency have a QA procedure, we suggest "Telehealth providers must have in place a systematic quality assurance and improvement program that includes telehealth services".	NC		BMS developed these requirements based on national quality standards pertaining to Telehealth as well as receiving feedback from BHHF who has participated in national conferences to help facilitate the building of BH Telehealth programs.
5/20/14	Page 14, last bullet; We believe that this requirement is redundant to already existing confidentiality requirements. Also the requirement that the patient have access to "all transmitted information" begs the question of the mechanics of such access. We would like to suggest that the bullet state "Right of the patient to documentation regarding all transmitted medical information".	C	2nd to last bullet on pg. 14 Clarified in Chapters 502 and 503	
5/20/14	Page 14, 6th bullet: …."must be an enrolled provider, a contracted employee or an employee of the enrolled provider"…….	C	Added "contracted employee" to Chapters 502 and 503	

5/20/14	Page 15, staff credentials in 503.15.1; We would like to include suitably trained registered nurses as able to provide this service. Also, final sentence in that paragraph should specify "internal credentialing process" rather than committee since small agencies may not have committee but may have an identified credentialing officer.	C	Added "RN" to Chapter 502 and 503	
5/20/14	Page 17; 503.15.1 Item M should state "Efficacy of and compliance with past treatment".	C	Added "of" to Chapters 502 and 503	
5/20/14	Also we had previously agreed that a 90791 could be performed at same initial or repeat assessment if further professional evaluation was required to confirm a diagnosis suggested by a non-licensed individual.	NC		FAQ BMS does not allow these codes to be billed on the same day.
5/20/14	Page 19, Documentation, 7th bullet: "Current and past medication as reported by the patient". We would not have access to true information regarding efficacy or compliance in most cases.	NC		FAQ The provider should document this information based on the sources available and citing those sources.

5/20/14	Page 19, Documentation: bullet 12: change requirement for prognosis to “Possible barriers to treatment” unless an evaluation is conducted to confirm a diagnosis, in which case the bullet would be irrelevant. Prognosis is a very relative term, generally meaningless and at times, counterproductive.	C	Added “prognosis and rationale” to Chapters 502 and 503	
5/20/14	Page 19, Documentation, bullet 13: Rationale for diagnosis; The body of the report should justify the diagnosis. This requirement is “make work” that is duplicative.	NC		
	Page 22, Coordinated Care, third paragraph: Development of the initial plan without the “current” rather than “entire” interdisciplinary team. Rationale: at the time an initial plan is developed only the clinician, the member, and the authorizing professional may constitute the IDT. We are concerned that this could later be interpreted as the team as it eventually becomes when fully formed and therefore invalidate the billing.	NC		FAQ Development of the initial plan without the entire interdisciplinary team is not a billable service (see Service Plan Development for clarification and description of exceptions).

5/20/14	Page 22, Coordinated care, third bullet: take out final sentence “If a program is an intensive service…..7 days” since we have no definition for intensive service….	C	Added definition of Intensive Services to Chapter 502 and Chapter 503	
5/20/14	Page 24, third paragraph, “The physician or designated physician extender” should also include licensed or supervised psychologist.	D		
5/20/14	Page 24, second paragraph should include physician extender, licensed or supervised psychologist.	C	Added “Physician Extender” to Chapters 502 and 503	
5/20/14	Page 24, first bullet. We had agreed that this would be stated as “Receive psychotropic medications prescribed by the agency”.	C	Language was added to Chapters 502 and 503	
5/20/14	Page 25, first bullet under documentation: We had agreed that there would be no requirement for a case manager note since the treatment plan was the final document and a permanent product of the meeting. Therefore we recommend eliminating this bullet altogether.	C	Removed the bullet from Chapters 502 and 503	

5/201/14	Page 26, 503.16.2; should include availability through Telehealth. Additionally we have questions as to how signatures can be obtained in ink, as required in bold print, in an electronic records system. Clarification?	D		
5/20/14	Page 28 Staff credentials; In the past a bachelor's level ADC could bill H0004 HO however this revision requires a master's degree. We understand that the individual must be credentialed and working only with substance use disorders. Could you consider an exception for BA level ADCs. Also, last sentence in first paragraph, suggest changing to "….the ADCs must be licensed in their respective professional disciplines".	NC		The staff credentials required for Professional therapy is Master's Degree
5/20/14	Page 29, Staff Credentials refers in mid paragraph to Behavioral Health Counseling, Individual, when the section applies to Group. Same comment last sentence of second paragraph under definition (third paragraph on page).	C	Corrected in Chapters 502 and 503	

5/20/14	Page 34, 503.19.2; Last bullet on page; should not be required if all staff involved are employed by same agency. (Coordination of Care agreement).	C	If in the same agency no coordination of care agreement needed Language added to Chapter 502 and 503	
5/20/14	Page 35, second bullet; should include exception for agreement for physicians as well as therapists and since many Suboxone programs are focused care there would be no Master Service Plan. Suggest paragraph read "If a change of physician or therapist takes place, a new agreement must be signed. The agreement is not required to be updated if the member is changing therapists or physicians within the same agency. This agreement must be placed in the member's record and updated annually."	NC		FAQ No, the agreement is not required if the member is receiving services at an agency where both the physician and therapist are employed.
5/20/14	Page 37, Titration policy: Received numerous complaints about requirement for Board Certification. This is nonsensical since any physician who has completed the appropriate Suboxone training and certification process is eligible to provide the service. If a gynecologist is providing Suboxone treatment, what	C	Removed WV Board of Medicine statement from Chapters 502 and 503	

	difference would board certification make?			
5/20/14	Page 39, Day program: Staff requirements: Licensed or supervised psychologist, Licensed Professional Counselor (first two bullets).	C	Added LPC and Supervised Psychologist to Chapters 502 and 503	
5/20/14	Page 39, Day program: requirement for staff training and credentialing in developmental disabilities does not make sense if the day program does not deal with DD population. Requirement should be for disability specific training and/or experience.	D		
5/20/14	Page 41, Comprehensive Community Support Services: Use of term “maintenance” throughout will trigger issues with CMS. We recognize that alternative language has been proposed to CMS but suggest removal of Maintenance language in this manual until suggested alternative language is accepted/rejected.	NC		No changes will be made to CCSS

5/20/14	Page 43, Staff Qualifications: There is no such thing as a Qualified Mental Health Professional. Suggest removing this requirement.	NC		No changes will be made to CCSS
5/20/14	Page 44, 4th paragraph. Redundant. Of course every member has to have a clinical record. And the term "Permanent" is very problematic. Remove paragraph entirely.	NC		BMS is clarifying that every member needs a permanent clinical record.
5/20/14	Page 45, 503.21.2; Telehealth policy is confusing. Either telehealth is available or it's not. Suggest that telehealth be available at all times, however if not, requirement must be clarified to state under what terms it can be used. Also required face to face meeting with physician should include physician extender if it remains.	NC		BMS has identified each service has "Available" or "Unavailable" pertaining to Telehealth

5/20/14	Page 45, 503.21.2; Acute psychiatric hospitals are required to have the physician review the patient five of seven days. It is excessive for the requirement to be daily for a community based program of care that is less intensive than acute hospital based psychiatric care.	NC		CSU is an high intensive level of care service and physician oversight is needed to help stabilize the patient.
5/20/14	Page 45, final paragraph. We recommend requiring either an LPN plus a second staff or a Bachelor's level plus a second staff, but not both LPN and BA. This is burdensome and unnecessary.	D		
5/20/14	Page 46, Comprehensive Psychiatric Evaluation: We had agreed that the totality of documentation at intake must include all the detailed items here, not pieces conducted by specific staff. The descriptor "may be completed by ancillary staff person" will create problems for agencies unnecessarily. If you use that term why would Item G not be eligible to be completed by ancillary staff? We suggest that the agreement reached in our prior meeting be left to stand: that is,	C	Language was changed in Chapters 502 and 503 The ancillary staff may do G now.	

	that regardless of who collects the information, it must be present in the record.			
5/20/14	Page 48, bullets under Psychiatric signs and symptoms: Plural of criterion is criteria. Also in second bullet it says that “one of the three criterions must be met” but there are only two to pick from.	C	Grammar was checked in Chapters 502 and 503	
5/20/13	Page 52, ACT. Definition needs to include addictions, also first bullet under purpose.	D		
5/20/14	Page 49: same problems with “criterions”.	C	Grammar was checked in Chapters 502 and 503	
5/20/14	Page 53, Member participation criteria should include admissions for treatment of addictions, stays in detox or residential treatment centers.	NC		ACT has specific criteria for entrance into the program. Refer to State Plan for further information
5/20/14	Page 54, first sentence, should allow exception for weekends as well as federal holidays.	D		
5/20/14	Page 54, requirement that physician be available for 16 hours. Can this be less for very small teams (e.g, under 30 members).	NC		Refer to State Plan

5/20/14	Page 54, ACT service elements, second bullet: “Sustained effort to engage the member in treatment, medication education and prompting, and skill development activities”…..	C	Added the sentence to Chapter 503	
5/2014	Page 55: Team leader is a practicing clinician 50% of the time. Request for clarification as to definition of “practicing”.	NC		FAQ Practicing refers to active involvement with members. The team leader should not perform 100% administrative functions.
5/20/14	Page 55, Fidelity indicator, needs to make exceptions for weekends re: daily meeting. .	NC		This a national ACT Standard
5/20/14	Page 55: requirement for one registered nurse per 50 consumers. Can a census of 50 to 75 be served with a registered nurse and an LPN?	NC		Fidelity Factors could not be measured if we made this change
5/20/14	Page 55, Fidelity indicator requirement for 95% or more full staffing; question ability of providers to ensure this in a high burnout profession with lack of available work force in many	NC		National Standard pertaining to ACT

	positions, particularly licensed professionals and nursing			
5/20/14	Page 56, requirement for two hours face to face per week. Can this be averaged over 90 days? Example “Each member receives an average of two hours of face to face contact with a team member per week”.	D		
5/20/14	Page 57, requirement for documentation of each medication delivery perceived by some as burdensome. Also requirement for appropriate storage in home with children and/or incapacitated adults. “We have no legal authority to mandate how anyone stores their meds”.	NC		FAQ Due to the inherent risks associated with medication delivery, it is necessary to establish protocols to promote safety, security, and accountability. As per the manual, the delivery date, time, person receiving and name of medication delivered is documented, including amount delivered (the list of medications and dosages may be contained in the member record however each delivery must be logged either in the member record or in a central location). If there are children or other incapacitated adults in the home, medications are at least

				initially stored properly in a secure location. The worker cannot assure how the medication is managed after delivery, but must document each delivery.
5/20/14	Residential programs for children reference ICD 9 and DSM IV. Suggest consistent use of “current ICD or DSM” rather than specifying. ”	C	Changed language to clarify to current ICD and DSM in Chapter 503	
5/20/14	Page 74, 503.24.1, “re-enforcers” need to be “reinforcers”. Also unclear under what circumstances would use “protocol” vs. “plan	C	Checked grammar in Chapter 503	
5/20/14	Numerous concerns about the ACT certification application. Particularly the policy requirements on Page 7. Our experience with OHFLAC has been that no provider can think of every exigency that may occur in an emergency and plan for it, yet if	NC		FAQ Medicaid recognizes that every scenario cannot be predicted, however the provider should have a plan in place to address multiple emergent situations.

	the agency does not include a particular situation in its policy, or for some valid reason, does not follow its policy, statements of deficiency occur regardless of the outcome. It is also very difficult to write a policy for dealing with aggressive behavior since each episode is different and is vastly affected by the unique characteristics of the consumer, the staff, and the environment. We would like more clarification on what is expected in such policies and will be happy to 'write to the test' and train accordingly. Will current providers be expected to submit new applications for certification of teams and programs?			
5/20/14	Here are some comments for the ACT section of the manual. 1. Page 54 indicates that ACT Team cannot serve non-ACT members. a. Is this the case if they have extra staff above the 5 "core" staff? If so can this be put in the manual?	NC		FAQ With the exception of the team physician and physician extender, if any, the core ACT Team cannot serve non-ACT members. ACT team members in addition to the core 5 may serve non-ACT members as long as the 1:10 ratio is still met for ACT. The physician and/or physician extender works at

				least 16 hours per week on teams with 50 clients, and proportionally more on larger teams.
5/20/14	Please define rural versus urban	D		
5/20/14	Page 55 indicates that 75% of services delivered outside of program offices. Then page 56 indicates "outside of clinic setting Is this meaning the same thing? Does this mean only 25% can be provided at the agency site?	NC		FAQ Yes, 75% of services must be provided outside of and at sites other than the main office. If you need further clarification, please contact the BMS Program Manager.
5/20/14	Top of page 54 indicates "The ACT Team must meet daily to review all cases in their caseload except on federally recognized holidays". a. On page 58 it indicates "A log documenting the discussion of each member in the daily team meeting	NC		FAQ In order to adhere to the fidelity factors, program meetings are held daily. They are not held on federally recognized holidays.

	(excepting weekends and holidays)". b. This seems contradictory. Do they need to meet on weekends and holidays or just not federally recognized holidays? Please clarify.			
5/20/14	Thank you for the opportunity to comment on the proposed Rehab Manual changes. My comments are as follow: Page 6 – 503.4.2 Enrollment Requirements: Staff Qualifications "A Physician's Assistant (PA) and/or Advanced Practice Registered nurse must have a signed collaborative agreement for prescriptive authority with a psychiatrist." Comment: For the PA - A collaborative agreement is only required for a nurse practitioner (since they are practicing independently), while a PA is	D		

	required to be under the direct supervision of the physician.			
5/20/14	Page 8 – 503.7 Service Certification Requirements "A physician or physician extender must certify the need for Behavioral Health Rehabilitation Comment: Does this section mean that "no one" needs to certify the need for Behavioral Health Rehab services for "Focused Care" clients?	D		
5/20/14	Comment: Shouldn't "Licensed Psychologist" also be included?	D		

5/20/14	Page 11 503.11– Other administrative "The provider must assure implementation of BMS' policies and procedures pertaining to service planning, documentation, and case record review." Comment: What does "case record review" mean? .	NC		FAQ Medicaid and/or its contractors must be given access to review member records (See Provider Reviews).

5/20/14	"Documentation of the services provided in this manual must demonstrate only one staff person's time is billed for any specific activity provided to the member." Comment: We should add "with the exception of the service planning code" because you can bill more than one staff person's time for that particular service	NC		FAQ Service planning does allow participation of multiple clinicians at one time.
5/20/14	Page 12 – 503.12 – Focus and Coordinated Care Services include the following services that overlap with the service definition of Focused Care: Professional Individual Therapy Professional Group Therapy Professional therapy and medication management provided in the context of the Coordinated Care services	NC NC		FAQ See below FAQ Professional Individual and Group therapy are included in both Focused and Coordinated Care. Depending upon the service mix utilized, these services may quality as either one. For example, individual professional

	For example: Are these considered Coordinated when provided as part of an Intensive Service Program only OR would it be considered Coordinated if a client were receiving both group and individual simultaneously and each service was provided at minimum once a week?	NC		therapy and professional group used in combination as an IS program would be Coordinated Care. If the services were provided once per week on an outpatient basis with no other service, they would be considered focused. FAQ See above

	Are these considered Coordinated Care when provided in conjunction with the prescription of Suboxone or Vivitrol treatment? If yes, do all of these services have to be provided at the same agency to be considered as Coordinated or can the member receive therapy from one provider and medications through another provider?	NC		FAQ Members may receive services from multiple providers as long as services are not duplicative. Depending upon the phases of the Non-Methadone Medication Assisted Treatment, the member may move from Coordinated to Focused depending upon the members clinical stability.
	Comment: If a Medicaid Member is considered to be in *Focused Care* then a provider cannot bill for a Service Plan and/or Treatment Plan. No 72 hour Authorization is required for individuals receiving only Focused Treatment Services. Does this mean we can complete an Intake, schedule for therapy and medication services only with no authorization for services form from a physician or licensed psychologist	NC		FAQ Yes, that is correct.

5/20/14	Page 22 – Service Planning "If a program is an intensive service the master plan must be completed within 7 days…." Comment: What is an "intensive service"? Should this read "coordinated service"?	D		
5/20/14	Page 24 – 503.16.1 -- Service Plan Development "The physician or designated physician extender must be present physically or by Telehealth and participate in all service planning sessions for members who meet any of the following criteria . . . . " Comment: This sentence should include "licensed psychologist" after physician extender?	D		

5/20/14	Page 26 – 503.16.2 Mental Health Service Plan Development by Psychologist Comment: Is this service available by Telehealth for the Psychologist? If so, it was inadvertently omitted.	D		
5/20/14	Comment: Typically this is an intake and the primary purpose is gathering of information. Can this be provided by an RN with specialized training (would be more than comparable to a BA level staff) for programs like CRUs and Detox? In programs such as Crisis Residential and Detox,	D		

	nurses are responsible for assessment on evening and overnight hours. Assessment in these programs needs to be done immediately, particularly related to health problems			
5/20/14	Comment: Has the service limitation of 15-min per month been eliminated?	D		
5/20/14	Documentation: "Documentation must contain the licensed psychologist's signature, in ink, on the completed service plan or service plan update….." Comment: "IN INK" should be removed. Electronic documentation systems are accepted practice.	D		
	Page 28 and 29 --- 503.17.2 Individual and Group Professional Therapy codes Alcohol and Drug Counselors (ADCs) are considered to be	D		

	credentialed to provide Behavioral Health Counseling, Individual, so long as they have a master's degree in a clinical field, but only when directly addressing Substance Abuse treatment issues. Comment: Should this say "bachelor's degree"? Or are you saying that a Bachelor's degreed ADC cannot provide individual therapy?			
	Page 29 - 503.17.2 – Group therapy There appear to be typo errors on page 29 in the 2nd and 4th paragraphs - Comment: Appeared to have copied the word "individual" when it should have been "group".	D		

	Page 29 - 502.17.3 Behavioral Health Counseling, Supportive, Individual: Definition is “face-to-face intervention provided to a member receiving coordinated care. Comment: Is not a professional therapy service: Currently this can be provided by paraprofessional staff with training. This has been effective. There is a dichotomy going on between BHHF and BMS. BHHS is moving to many staff being paraprofessionals instead of degreed staff (peer recovery/support; community engagement specialists (formerly care coordinators) while BMS is moving toward less paraprofessional and more degreed. Example: BHHF supporting paraprofessional peer recovery coaches to bill and BMS requiring BA level staff to bill supportive counseling, which is done well by recovery coaches	NC		BMS researched other states and found that many of them require at least a BA Level for Behavioral Health Counseling Supportive Individual and Group and with that information we developed the staff requirement for this service

	and other paraprofessional staff.			
	Page 34 – 503.19.2 Non-Methadone Medication Assisted Treatment All physicians agree to adhere to the Coordination of Care Agreement (See Attachment A) which will be signed by the member, the treating physician and the treating therapist. Comment: Could we change this to indicate the Coordination of Care and Release of Information between Suboxone/Subutex/Vivitrol Provider and BH Provider (Attachment A) is not required for clients who are receiving medication management and BH professional services from the same agency?	D		

	Page 35 – If a change of physician or therapist takes place, a new agreement must be signed. The agreement is not required to be updated if the member is changing therapists within the same agency and has an active Master Service Plan. Comment: The manual seems to indicate a client receiving Non-Methadone Medication Assisted Treatment may or may not require Coordinated Care Service Planning, depending on the other services they receive. That means they may or may not have a Master Service Plan. Can we delete the words “and has an active Master Service Plan”?	NC		All Service Plans if developed for a member must be active
5/20/14	Page 36 -- Documentation: Documentation for a coordinated care member must include a Master Service Plan that includes individual therapeutic	D		

	interventions Comment: We assume all Non-Methadone Medication Assisted Treatment (suboxone) clients would not necessarily be considered “Coordinated Care Clients”. If that’s true, can we change the language to read “If the member is receiving coordinated care services, documentation must include a Master Service Plan that includes individual therapeutic interventions.”			
5/20/14	503.20.1 Crisis Intervention: Comment: Recommend adding LICSW to review of pertinent documentation and findings to be consistent with State Code, which allows LICSWs to provide commitment evaluations.	NC		Crisis Intervention is not intended for use in the commitment process as such state code does not apply to this service.

5/20/14	Page 45 – 503.21.2 Community Psychiatric Supportive Treatment “Telehealth: Available – for medical services provided by a physician or physician extender only. Daily face to face meeting with physician must be in person.” Comment: Previous discussions had indicated Telehealth could be used in extenuating circumstances (such as extreme weather, etc.). What is written here seems contradictory. Can we change it to read “Daily face to face meeting with physician must be in person, except in extenuating circumstances, when telemedicine may be used.	NC		FAQ Telehealth may be used in CSU for documented extenuating circumstances i.e. medical emergency or weather related conditions

5/20/14	Definition: "There must be a minimum of two staff present onsite at all times Community Psychiatric Supportive Treatment is provided, one of which must have a Bachelors level degree or higher in a human service related field. The other staff must have an LPN or higher degree in the medical field." Comment: We believe this should be changed to require "either a bachelor level staff OR an LPN or higher", and it should be required only when services are being provided. Requiring both is onerous and unnecessary.	D		
5/20/14	Page 46 The program must have access to a psychiatrist/physician to provide psychiatric evaluations, medication orders at all times.	C	Added Extenders to Chapter 503	

	Comment: We should modify to include physician extenders as well?			
5/20/14	Bullet G: Developmental, psychosocial and sociocultural history Comment: We should include "Can be provided by ancillary staff" as is the case with the others?	D		
5/20/14	5.3.22 Assertive Community Treatment: Comment: "D, E, and G": Why can't they be completed by an ancillary staff person? Recommend changing to be in line with other areas that can be. The only issue I see would be in 'E' where it says concerns with medical detox. That could be pulled out.	NC		The physician or physician extender needs to complete D and E as they are medical related.

5/20/14	One of the purposes of act is to "increase the cognizance of the member to the need for medication compliance" (page 52), yet medication services cannot be the only service provided. In many cases this is the one service that is needed and the only service that some consumers will allow. Page 54 refers to a "sustained effort" to engage the member in treatment: we believe that med prompts and education is very much a sustained effort and is what keeps most of the act population out of psychiatric hospitals.	D		
5/20/14	page 55 under fidelity indicators("team leader is a practicing clinician 50% of time"): Can we get a more specific definition of what practicing entails?	D		

5/20/14	page 55 under fidelity ("program operates at 95% or more of full staffing on average over a 12 month period"): Question the appropriateness of this. We don't have total control of staff turnover and many times it takes some time to replace a staff.	D		
5/20/14	page 55 under fidelity "The physician/physician extender works at least 16 hours per week on teams with 50 clients, proportionally more on larger teams;" What is the requirement for teams under 50 clients? It should be proportionally fewer hours required for programs under 50 consumers	D		
5/20/14	page 55 under fidelity("each team has one full time registered nurse in a program of 50 clients"): For a team with a census of 75 will a RN	D		

	and LPN be sufficient or for teams over 50 does an additional RN need hired?			
5/20/14	page 56 (“each member receives at least four contacts per week of any type): This is addressed previously	D		
5/20/14	page 57 (medication delivery and monitoring): This can be a very time consuming process to document each delivery. Also regarding stored meds at a consumer’s home; we have no legal authority to mandate how anyone stores their meds.	D		
5/20/14	What is the time frame for looking at averages? Can we do this on a 90-day basis as we review treatment plans? Example: “Each member receives an average of two hours of face to face contact with a team member per week”	D		

5/20/14	How long to we monitor not meeting 2-hr face-to-face or 4 contacts before an individual no longer qualifies for ACT.	D		
5/20/14	Page 75 - 503.25 Transportation Services Behavioral Health Transportation Services are the services used to physically transport a Medicaid member to/from a therapeutic or diagnostic Medicaid service that is designated in the ***member's service plan.*** Comment: The language here should be changed to state "designated in the member's service plan (for coordinated care clients only) or Treatment Strategy (for focused care clients)."	NC		Transportation Broker in place by July 1

5/20/14	Attachment A: Coordination of Care and Release of Information Suboxone/Subutex/Vivitrol Providers Comment: The “Coordination of Care Agreement and Release of Information” (Attachment A) seems to be several separate documents combined into one attachment	NC		FAQ This is one document that needs to be completed in full it should not be separated.

5/20/14	Page 2 of “Attachment A” looks to be the annual signed agreement to be placed in the patient record and updated annually. Would this be the appropriate use for this page?	NC		FAQ This is one document that needs to be completed in full it should not be separated.
5/20/14	Page 3 of “Attachment A” looks like a Release of Information to be used between a prescribing physician and a BH provider at separate agencies. Would this be the appropriate use of this page?	NC		FAQ This is one document that needs to be completed in full it should not be separated.

5/20/14	Page 4 and 5 of “Attachment A” look like they are template that could be used to communicate treatment information between providers from separate agencies but are not necessarily a required document. Is than an accurate description of these pages	NC		FAQ This is one document that needs to be completed in full it should not be separated.
	I notice that in several places the manual refers to the physician or physician extender being present and/or signing documents. This includes the 72 hour auth and treatment plans. We have always used a Psychologist. We are an in-home service provider and use psychologists for those duties. We are in a rural area and do not have access to psychiatrists or physicians. I purpose that Psychologists be permitted to sign these documents and the manual have psychologist added.	D		

	Concern over eliminating RBA bachelor degrees from the approved listing. We have some excellent staff that have their AA degree and are pursuing their RBA. Since it is not an approved degree for the change in 2016, those staff are not going be able to provide services. These are staff that have a lot of experience and provide high quality services to the clients. They are unable to get their BA or BS degree by the 2016 deadline due to expense, family obligations and working full time. I purpose that the RBA degree is accepted on a case by case basis.	NC		We eliminated the RBA in the TCM Manual effective Jan 2012. BMS is ensuring that policies are consistent.
	I have concerns over the change from psychologist to psychiatrist signing the 72 hour authorization for coordinated services. We are an in-home service provider and have psychologists on staff that have always signed our 72 hour auths and treatment plans. I noticed that the 72 hour auth refers to a psychiatrist signing it now. We are in a rural location and do not have any psychiatrists in the area that can perform this service. I purpose that a psychologist can continue to sign	D		

	the authorizations.			
	I propose a change in the codes and billing for individual and family therapy. Rather than it being classified and billed as one code, I purpose that it is separated into two separate services. We provide in home services and have had situations where there are two different therapists within our agency providing therapy. One provides individual and another provides family. We have also had some situations where families are receiving outpatient therapy that is individual but the therapist wants to refer them for family therapy in the home but we have to bill under the same code.	NC		HCPCS Codes are defined differently than the CPT Codes. Please see the 2014 HCPS and CPT Code Manuals for clarification
	Page 22, 503.16 Coordinated Care - It states that the development of the initial plan without the entire interdisciplinary team is not a billable service, however during the first 7 days from intake the full interdisciplinary team would be the client /DLR, service coordinator and/or intake worker and the physician/physician	D		

	extender/licensed psychologist, therefore making it a billable service.			
	Pg.24, 503.16.1 Mental Health Service Plan Development – It states that all service plans (including updates) must be reviewed, signed, and approved by a physician within 72 hours of the service plan meeting and prior to implementing services. Physician extender, licensed psychologist and supervised licensed psychologist should be added. In the following paragraph, Licensed Psychologist or Supervised Licensed Psychologist should be added.	D		
	Page 26, 503.16.2, Mental Health Service Plan Development by a Psychologist – Telehealth availability should be added. Under documentation it states that signature must be in ink, however, electronic signature is acceptable practice in WV.	D		

	Page 28, 503.17.1 Behavioral Health Counseling, Professional, Individual – Under "Documentation" it states that documentation must indicate how often this service is to be provided. This information would be provided on the treatment plan for Coordinated Care or the Treatment Strategy for Focused Care, so this becomes redundant.	NC		FAQ Documentation must indicate how often this service is to be provided. A change in frequency of the service may occur based on Medical Necessity before the next service planning meeting is conducted.
	Re: Staff Credentials (Applies to both Individual and Group) Discussion: There is no advantage to distinguishing an ADC can provide the service if you are going to also require that they have a master's degree. Counseling is a core function of the ADC, but that credential level does not require a degree. ADCs were also allowed to provide these services in the current manual and consider should be given to allowing this to continue. Furthermore, treating an addiction requires specialization. If the intent is allow an ADC to provide therapy, as they have been up to this point in the manual,	NC		Anyone providing professional therapy must have a Master's Degree

	Recommend: a) Consider allowing an ADC under the supervision of an AADC, or b) *Require any therapy services that address Substance Use issues to be provided by someone with a Master's degree in human services and either has an addiction credential, actively pursuing an addiction credential, or is under the supervision of an AADC or equivalent.			
	Page 30, 503.17.3, Behavioral Health Counseling, Supportive, Individual – Under "Definition" it states that it must directly support another Behavioral Health Service to meet service definition and medical necessity. Can this include TCM? Staff Credentials- **1.** Doesn't mention current staff requirements. Recommend outlining the current staff credential requirements for any potential new providers/new staff between now and two years post release date of	D		

	this chapter. Rationale: Counseling is a core function of the ADC credential, rendering them qualified to provide this service when the focus is substance use issues.			
	Recommend the addition: (after the first sentence) Alcohol and Drug Counselors (ADCs) are considered to be credentialed to provide Behavioral Health Counseling, Supportive, Individual when directly addressing Substance Abuse treatment issues. To provide supportive counseling in other treatment areas, the ADCs must meet the minimum requirement of a bachelor's degree in a human services field	NC		
	Page 34, 503.19.2 NON-METHADONE MEDICATION ASSISTED TREATMENT 1. Therapy Services (pg. 35)- Discussion: I don't see the need to distinguish these	NC		

	staff requirements from the 503.17.1 and 503.17.2 services when the focus of the therapy services is to address substance use disorders. Treating a Substance Use disorder requires specialization, re: SAMSHA's TAP 21, TAP 21A. Recommend it read: "Any therapeutic intervention applied must be performed by a minimum of a Master's level therapist using generally accepted practice of therapies recognized by national accrediting bodies for psychology, psychiatry, counseling, and social work, *and* either have an addiction credential, actively pursuing an addiction credential, or are under the supervision of an AADC or equivalent. "			
	2. Non-Methadone MAT Guidelines: A. (Page 34) Last bullet on page; The Coordination of	D		

	Care agreement should not be required if all staff involved are employed by same agency.			
	B. (Page 35), second bullet; should include exception for agreement for physicians as well as therapists and since many Suboxone programs are focused care there would be no Master Service Plan. Recommend paragraph read "If a change of physician or therapist takes place, a new agreement must be signed. The agreement is not required to be updated if the member is changing therapists or physicians within the same agency. The agreement must be placed in the member's record and updated annually."	NC		FAQ No, the agreement is not required if the member is receiving services at an agency where both the physician and therapist are employed.

	C. (Page 37) regarding the requirement the physician have a plan in place for when they are unavailable to address any medical issues or medication situations that should arise. Recommend the physician covering for the primary physician meet the same requirements as described in Physician Requirements section (page 35), i.e. that the manual read: "The physician taking responsibility for prescribing and monitoring the member's treatment while the primary physician is unavailable must have a degree as a Medical Doctor and/or Doctor of Osteopathic Medicine. Must be licensed and in good standing in the state of West Virginia. Requirements for the Drug Addiction Treatment Act of 2000 (DATA 2000) must be met by the physician unless indicated by Substance	NC		FAQ The requirements for Non-Methadone Medication Assisted Treatment must be met when the primary physician is unavailable.

	Abuse Mental Health Services Administration (SAMSHA). The physician must be an enrolled WV Medicaid provider so that treatment is not …..”			
	Page 45, 503.21.2, Community Psychiatric Supportive Treatment – Under Telehealth the statement is confusing. ON one hand it says that telehealth is available for medical services provided by a physician or physician extender only. Daily face to face meeting must be in person. What is the intent?	NC		FAQ Telehealth is available for CSU when documented extenuating circumstances occur such as a medical emergency or severe weather conditions
	Page 55, ACT Fidelity Factors, Bullet #4 – For a large program of at least 50 clients a supervisor providing 50% of his/her time in direct client service may compromise the program in areas of safety and compliance and overall supervision of the program. Recommend 30%.	NC		This is a national ACT Standard

	Page 77, 503.28, Rounding Units of Service – H0032AH has been left off the list of eligible services for rounding.	C	Added H0032AH to Chapters 502 and 503	
	Page 4 – 502.2 Member Eligibility Behavioral Health Clinic Services are available to all Medicaid members with a known or suspected behavioral health disorder. Each member's level of services will be determined when prior authorization for Behavioral Health Clinic Services is requested of the agency authorized by the BMS to perform administrative review. Comment: There is no mention that a client must have a "clinic only eligible diagnosis". Is that still the case?	NC		FAQ "Clinic only" diagnosis is not required. When addressing the "clinic" diagnosis in treatment, the Clinic services may be utilized even when other diagnoses are present. However, if the focus of treatment is on the "Non-Clinic" diagnosis, the Rehabilitation service should be utilized.
	Page 5 – 502.3 Medical Necessity Comment: In the sentence "Medical Necessity must be demonstrated *throughout* the provision of services" could the word *throughout* be changed to " . . . . . *periodically* ? Comment: The second bullet (Diagnosis) should include "physician extenders" and	D		

	"behavioral health professional within their scope of practice".			
	Page 5 – 502.4.1 Enrollment Requirements: Agency Administration Comment: In the first sentence please add the words "or Credentialing Officer" after Credentialing Committee.	D		
	Page 6 – 502.4.2 Enrollment Requirements: Staff Qualifications "A Physician's Assistant (PA) and/or Advanced Practice Registered nurse must have a signed collaborative agreement for prescriptive authority with a psychiatrist." Comment: For the PA - At this time, a collaborative agreement is only required for a nurse practitioner (since they are practicing independently), while a PA is required to be under the direct supervision of the physician. Therefore, no "collaborative agreement" is required for a PA at this time. Is this meant to be a requirement in excess of the current Board of Medicine requirements?	D D		

	Page 8 – 502.7 Service Certification Requirements "A physician or physician extender must certify the need for Behavioral Health Clinic Coordinated Services . . . . Comment: Does this section mean that "no one" needs to certify the need for Behavioral Health Clinic services for "Focused Care" clients? Comment: The time frames in the manual say that the master treatment plan must be formulated within 30/days of admission. If a client becomes a "Coordinated Care" client after the 30/days from admission, then does the new treatment plan serve as "certification of the need for Behavioral Health Rehab services" instead of the 72-hour form?	D		
	Page 10 Plan of Correction Comment: This section is brand new and we have never had to do this before. We already create Plans of Correction for OHFLAC. We prefer that this requirement be removed.	D		

	Page 10-11 502.11– Other administrative Bullet 5: If requested the providers must provide copies of Medicaid members records within 24 hours of the request. Comment: We request 72 business hours to produce copies of requested medical records instead of 24 hours. Last bullet: Documentation of the services provided in this manual must demonstrate only one staff person's time is billed for any specific activity provided to the member. Comment: Can you add "with the exception of the service planning code" because you can bill more than one staff person's time for that particular service?			
	Page 12 – 502.12 – Focus and Coordinated Care Services include the following services that overlap with the service definition of Focused Care: • Professional Individual Therapy • Professional Group Therapy • Professional therapy and	D		

	medication management provided in the context of the Coordinated Care services Comment: Please clarify the difference in intensity or frequency that must be present or provided for these services to be viewed as Coordinated Care rather than simply Focused Care. For example: • Are these considered Coordinated when provided as part of an Intensive Service Program only OR would it be considered Coordinated if a client were receiving both group and individual simultaneously and each service was provided at minimum once a week? • Are these considered Coordinated Care when provided in conjunction with the prescription of Suboxone treatment? If yes, do all of these services have to be provided at the same agency to be			

	considered as Coordinated or can the member receive therapy from one provider and medications through another provider? • Are these considered Coordinated Care when provided in conjunction with the prescription of Clozaril?			
	Page 11 - Last Sentence in Focus Care paragraph: "The treatment strategy is a flexible tool guiding treatment which may consist of one or more of the following Medicaid services." Comment: This sentence makes it sound like the treatment strategy is a separate document – when we don't think that was the intent. Is it possible to change the sentence to read: *"The treatment strategy guides treatment and may consist of one or more of the . . . . ."*	D		
	Page 12 – Focus Care Services at top of page Comment: Is Suboxone treatment included in Focus Care treatment?	D		

	Page 12 – Services falling under Coordinated Care . . . . Comment: Is "Comprehensive Medical Services" (e.g. Clozaril) included under Coordinated Care?	D		
	Page 14 – Bullet 1: The operator of the Telehealth equipment must be an enrolled provider or an employee of the enrolled provider for compliance with confidentiality and quality assurance. Comment: Can you add the word "***contracted"*** after the word employee above. That will then include all of our contracted employees as well.	D		

	Comment: Under the third bullet --- What is an “intensive service”? Should this read “coordinated service” or can this whole last sentence be removed?	D		
	Comment: Under the third bullet --- What is an “intensive service”? Should this read “coordinated service” or can this whole last sentence be removed?	D		
	Page 22 – Service Planning First sentence in the third paragraph reads: “Development of the initial plan without the entire interdisciplinary team is not a billable service . .. “ Comment: Can the word “entire” be changed to “current” in order to satisfy the scenario of when a Treatment Plan is created at the intake session with the Intake Clinician and/or Psychologist and the client - as that will be the current treatment team. Once additional services are received then those clinicians and participants will become members and will attend future team meetings.	D		

	Third bullet: If a program is an intensive service the master plan must be completed within 7 days….			
	Page 23 – 502.16.1 -- Service Plan Development The first bullet: Receive psychotropic medications Comment: Can we change this to read "Receive psychotropic medications from the same provider agency" or stipulate someway that is only when the providing agency is prescribing medications. Some clients receive their medication from other agencies/physicians.	D		
	Page 26 and 27 --- 502.17.1 and 502.17.2 Individual and Group Professional Therapy codes Alcohol and Drug Counselors (ADCs) are considered to be credentialed to provide Behavioral Health Counseling, Individual, so long as they have a master's degree in a clinical field, but only when directly addressing Substance Abuse treatment issues.	D		

	Comment: Should this say "bachelor's degree"? We believe that a Bachelor's degreed ADC should be able provide individual therapy as they currently are?			
	Page 28 – 502.17.2 Group Professional Therapy Definition section – last sentence. Comment: Appeared to have copied "individual" when it should be "group".	D		

	Page 32 – 502.19.2 Non-Methadone Medication Assisted Treatment All physicians agree to adhere to the Coordination of Care Agreement (See Attachment A) which will be signed by the member, the treating physician and the treating therapist. Comment: Could we change this to indicate the Coordination of Care and Release of Information between Suboxone/Subutex Provider and BH Provider (Attachment A) is not required for clients who are receiving medication management and BH professional services from the same provider agency?	D		
	Page 32 – If a change of physician or therapist takes place, a new agreement must be signed. The agreement is not required to be updated if the member is changing therapists within the same agency and has an active Master Service Plan.	D		

	Comment: The manual seems to indicate a client receiving Non-Methadone Medication Assisted Treatment may or may not require Coordinated Care Service Planning, depending on the other services they receive. That means they may or may not have a Master Service Plan. Can we delete the words “and has an active Master Service Plan”?			
	Page 33 – Documentation: Documentation for a coordinated care member must include a Master Service Plan that includes individual therapeutic interventions Comment: We assume all Non-Methadone Medication Assisted Treatment (suboxone) clients would not necessarily be considered “Coordinated Care Clients”. If that’s true, can we change the language to read “If the member is receiving coordinated care services, documentation must include a Master Service Plan that includes individual therapeutic interventions.”	D		

	Page 39/40 – 502.20.2 Community Psychiatric Supportive Treatment "Telehealth: Available – for medical services provided by a physician or physician extender only. Daily face to face meeting with physician must be in person." Comment: Previous discussions had indicated Telehealth could be used in extenuating circumstances (such as extreme weather, etc.). What is written here seems contradictory. Can we change it to read "Daily face to face meeting with physician must be in person, except in extenuating circumstances, when telemedicine may be used.	D		
	Definition: "There must be a minimum of two staff present onsite at all times Community Psychiatric Supportive Treatment is provided, one of which must have a Bachelors level degree or higher in a human service related field. The other staff must have an LPN or higher degree in the medical field." Comment: We believe this should be changed to require "either a bachelor level staff OR an LPN or higher". Requiring both is onerous	D		

	and unnecessary.			
	The program must have access to a psychiatrist/physician to provide psychiatric evaluations, medication orders at all times. Comment: Is this meant to include "Physician Extenders" as well?	D		
	Bullet G: Developmental, psychosocial and sociocultural history Comment: Did you meant to include "Can be provided by ancillary staff" like the others?	D		
	Page 52 – 502.22 Transportation Services Behavioral Health Transportation Services are the services used to physically transport a Medicaid member to/from a therapeutic or diagnostic Medicaid service that is designated in the ***member's service plan***. Comment: The language here should be changed to state "designated in the member's service plan (for coordinated care clients only)."	D		

	• Page 4 and 5 of "Attachment A" look like they are template that could be used to communicate treatment information between providers from separate agencies but are not necessarily a required document. Is than an accurate description of these pages?	D		
	Attachment A: Coordination of Care and Release of Information Suboxone/Subutex/Vivitrol Providers Comment: The "Coordination of Care Agreement and Release of Information" (Attachment A) seems to be several separate documents combined into one attachment. • Page 2 of "Attachment A" looks to be the annual signed agreement to be placed in the patient record and updated annually. Would this be the appropriate use for this page?	D		

	• Page 3 of “Attachment A” looks like a Release of Information to be used between a prescribing physician and a BH provider at separate agencies. Would this be the appropriate use of this page?	D		
	Page 3 – Behavioral Health Rehabilitation Services Definition Comment: Add the words “physician extender” after physician; add the words “supervised psychologist” after licensed psychologist in the second line.	D		
	Page 5 – 503.4.1 Enrollment Requirements: Agency Administration Comment: In the first sentence please add the words “or Credentialing Officer” after Credentialing Committee.	D		
	Page 5 – 503.3 Medical Necessity Comment: In the sentence “Medical Necessity must be	D		

	demonstrated *throughout* the provision of services" could the word *throughout* be changed to " . . demonstrated *periodically* ? Comment: The first bullet (Diagnosis) should include "physician extenders" and "behavioral health professional within their scope of practice".	D		
	Page 6 – 503.4.2 Enrollment Requirements: Staff Qualifications "A Physician's Assistant (PA) and/or Advanced Practice Registered nurse must have a signed collaborative agreement for prescriptive authority with a psychiatrist." Comment: For the PA - At this time, a collaborative agreement is only required for a nurse practitioner (since they are practicing independently), while a PA is required to be under the direct supervision of the physician. Therefore, no "collaborative agreement" is required for a PA at this time. Is this meant to be a requirement in excess of the current Board of Medicine requirements?	D		

	Page 8 – 503.7 Service Certification Requirements "A physician or physician extender must certify the need for Behavioral Health Rehabilitation Coordinated Services . . . . Comment: Shouldn't "Licensed Psychologist" also be included? Comment: Does this section mean that "no one" needs to certify the need for Behavioral Health Rehab services for "Focused Care" clients? Comment: The time frames in the manual say that the master treatment plan must be formulated within 30/days of admission. If a client becomes a "Coordinated Care" client after the 30/days from admission, then does the new treatment plan serve as "certification of the need for Behavioral Health Rehab services" instead of the 72-hour form?	D		
	Page 10 Plan of Correction Comment: This section is brand new and we have never had to do this before. We already create Plans of Correction for OHFLAC. We prefer this requirement be removed.	D		

	Page 11 503.11– Other administrative Bullet 5: If requested the providers must provide copies of Medicaid members records within 24 hours of the request. Comment: We request 72 business hours to produce copies of requested medical records instead of 24 hours. Last bullet: Documentation of the services provided in this manual must demonstrate only one staff person's time is billed for any specific activity provided to the member. Comment: Can you add "with the exception of the service planning code" because you can bill more than one staff person's time for that particular service?	D		
	Page 12 – 503.12 – Focus and Coordinated Care Services include the following services that overlap with the service definition of Focused Care: Professional Individual Therapy Professional Group Therapy Professional therapy and medication management provided in the context of the Coordinated	D		

	Care services Comment: Please clarify the difference in intensity or frequency that must be present or provided for these services to be viewed as Coordinated Care rather than simply Focused Care. For example: • Are these considered Coordinated when provided as part of an Intensive Service Program only OR would it be considered Coordinated if a client were receiving both group and individual simultaneously and each service was provided at minimum once a week? • Are these considered Coordinated Care when provided in conjunction with the prescription of Suboxone treatment? If yes, do all of these services have to be provided at the same agency to be considered as Coordinated or can the member receive therapy from one provider			

	and medications through another provider? • Are these considered Coordinated Care when provided in conjunction with the prescription of Clozaril?			
	Last Sentence in Focus Care paragraph: "The treatment strategy is a flexible tool guiding treatment which may consist of one or more of the following Medicaid services." • Comment: This sentence makes it sound like the treatment strategy is a separate document – when we don't think that was the intent. Is it possible to change the sentence to read: *"The treatment strategy guides treatment and may consist of one or more of the . . . . ."*	D		

	• Comment: Is Suboxone treatment included in Focus Care treatment?	D		
	Page 13 – Services falling under Coordinated Care . . . . • Comment: Is "Comprehensive Medical Services" (e.g. Clozaril) included under Coordinated Care?	D		
	Page 14 – Bullet 7: The operator of the Telehealth equipment must be an enrolled provider or an employee of the enrolled provider for compliance with confidentiality and quality assurance. Comment: Can you add the word "***contracted"*** after the word employee above. That will then include all of our contracted employees as well.	D		

	Comment: Under the third bullet --- What is an “intensive service”? Should this read “coordinated service” or can this whole last sentence be removed?	D		
	Page 22 – Service Planning First sentence in the third paragraph reads: “Development of the initial plan without the entire interdisciplinary team is not a billable service . .. “ Comment: Can the word “entire” be changed to “current” in order to satisfy the scenario of when a Treatment Plan is created at the intake session with the Intake Clinician and/or Psychologist and the client - as that will be the current treatment team. Once additional services are received then those clinicians and participants will become members and will attend future team meetings. If a program is an intensive service the master plan must be	D		

	completed within 7 days….			
	Page 24 – 503.16.1 -- Service Plan Development The second full sentence: "The physician or designated physician extender must be present physically or by Telehealth and participate in all service planning sessions for members who meet any of the following criteria . . . " Comment: Can we change this sentence to include "licensed psychologist" after physician extender? The first bullet: Receive psychotropic medications Comment: Can we change this to read "Receive psychotropic medications from the same provider agency" or stipulate someway that is only when the providing agency is prescribing medications. Some clients receive their medication from other agencies/physicians. must contain the licensed psychologist's signature, <u>in ink</u>, on the completed service plan or service plan update….." Comment: "IN INK" should be removed. Electronic	D		

	documentation systems are accepted practice.			
	Page 26 – 503.16.2 Mental Health Service Plan Development by Psychologist Comment: Is this service available by Telehealth for the Psychologist? If so, it was inadvertently omitted. Comment: Has the service limitation of 15-min per month been eliminated? Documentation: "Documentation	D		
	Page 28 and 29 --- 503.17.2 Individual and Group Professional Therapy codes Alcohol and Drug Counselors (ADCs) are considered to be credentialed to provide Behavioral Health Counseling, Individual, so long as they have a master's degree in a clinical field, but only when directly addressing Substance Abuse treatment issues. Comment: Should this say "bachelor's degree"? We believe that a Bachelor's degreed ADC should be able provide individual therapy as they currently are?	D		

	Page 29 - 503.17.2 – Group therapy There appear to be typo errors on page 29 in the 2nd and 4th paragraphs - Comment: Appeared to have copied the word “individual” when it should have been “group”.	D		
	Page 34 – 503.19.2 Non-Methadone Medication Assisted Treatment All physicians agree to adhere to the Coordination of Care Agreement (See Attachment A) which will be signed by the member, the treating physician and the treating therapist. Comment: Could we change this to indicate the Coordination of Care and Release of Information between Suboxone/Subutex Provider and BH Provider (Attachment A) is not required for clients who are receiving medication management and BH professional services from the same Provider agency?	D		

	Page 35 – If a change of physician or therapist takes place, a new agreement must be signed. The agreement is not required to be updated if the member is changing therapists within the same agency and has an active Master Service Plan. Comment: The manual seems to indicate a client receiving Non-Methadone Medication Assisted Treatment may or may not require Coordinated Care Service Planning, depending on the other services they receive. That means they may or may not have a Master Service Plan. Can we delete the words “and has an active Master Service Plan”?	D		
	Page 36 -- Documentation: Documentation for a coordinated care member must include a Master Service Plan that includes individual therapeutic	D		

	interventions Comment: We assume all Non-Methadone Medication Assisted Treatment (suboxone) clients would not necessarily be considered “Coordinated Care Clients”. If that’s true, can we change the language to read “If the member is receiving coordinated care services, documentation must include a Master Service Plan that includes individual therapeutic interventions?” OR . . . . Are Non-Methadone clients considered “Coordinated Care Clients”?			
	Page 41 – 503.20.2 – Comprehensive Community Support Services Comment: The definition section contains the word “maintain” several times. We thought that this service was no longer a maintenance service.	D		

	Page 43 – Staff Qualifications – First Bullet Comment: First bullet refers to a Qualified Mental Health Professional (QMRP). Since that QMRP term is no longer used can that phrase in the sentence be changed to “person” with a minimum of a Bachelor’s degree . . . . .?	D		
	Page 45 – 503.21.2 Community Psychiatric Supportive Treatment “Telehealth: Available – for medical services provided by a physician or physician extender only. Daily face to face meeting with physician must be in person.” Comment: Previous discussions had indicated Telehealth could be used in extenuating circumstances (such as extreme weather, etc.). What is written here seems contradictory. Can we change it to read “Daily face to face meeting with physician must be in person, except in extenuating circumstances, when telemedicine may be used. Definition: “There must be a minimum of two staff present onsite at all times Community	D		

	Psychiatric Supportive Treatment is provided, one of which must have a Bachelors level degree or higher in a human service related field. The other staff must have an LPN or higher degree in the medical field." Comment: We believe this should be changed to require "either a bachelor level staff OR an LPN or higher". Requiring both is onerous and unnecessary.			
	Page 46 The program must have access to a psychiatrist/physician to provide psychiatric evaluations, medication orders at all times. Comment: We should modify to include physician extenders as well? Bullet G: Developmental, psychosocial and sociocultural history Comment: We should include "Can be provided by ancillary staff" as is the case with the others?	D D		

	Page 75 - 503.25 Transportation Services Behavioral Health Transportation Services are the services used to physically transport a Medicaid member to/from a therapeutic or diagnostic Medicaid service that is designated in the ***member's service plan***. Comment: The language here should be changed to state "designated in the member's service plan (for coordinated care clients only)."	D		
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	Page 4 and 5 of “Attachment A” look like they are template that could be used to communicate treatment information between providers from separate agencies but are not necessarily a required document. Is than an accurate description of these pages	D		

	Page 53 of the Rehab Manual states that the ACT Team must have 2 to 3 Master's Level staff on the team. Southern Highlands is considering an ACT but I doubt that we will be able to recruit that many Master's level employees. In the previous manual, I believe that the requirement is 1 or 2 depending on the Team Leader. I believe that it should not be increased to require an additional Master's level staff. Thank you for the opportunity to comment.	NC		Please Refer to State Plan. BMS understands your concern however due to the State Plan that is effective July 1, 2010 we are unable to make changes to this portion of the policy.
	Question 503.16.1 regarding the use of a psychologist for service planning. Pages 23 and 24 only reference the use of a physician or physician extender. It is not until the next to last paragraph on page 25 that it references the participation of a psychologist. I think this may lead to some confusion.	D		

Note: FAQ's are to be considered Policy Clarifications.