Comments for Chapter 503 Licensed Behavioral Health Center (LBHC) Services Manual
Effective Date: 7/15/18

Date Received	Comment	Response
6/5/18	First, throughout the manual in relation to Telehealth Service provision there is the comment that various services are "Available with GT Modifier." In January 2017 CMS removed the use of the GT modifier for identification of telehealth services and instead now requires the use of a **Place of Service (POS) 02: Telehealth** rather than the GT modifier. Molina utilizes this POS code now within WV Medicaid as well. Second (also related to Telehealth services), I feel it would be reasonable and advantageous to allow for the daily face to face meeting with the physician in Community Psychiatric Supportive Treatment (H0036) to also be permitted via telehealth. The daily meeting is similar in function and complexity to an Evaluation and Management service, which is permitted as a telehealth contact. Many of our medical providers are remotely located and permitting telehealth daily review within the crisis stabilization program would be both clinically and logistically advantageous.	No Change: WV BMS has determined that we would continue to use the GT Modifier as well as the POS 02. No Change: WV BMS has determined that telehealth in conjunction with H0036 can only be used in case of emergencies i.e. weather-related issues that causes the physician or physician extender to unable to report to complete face to face meetings and services.
6/7/18	Comprehensive Medication Services; Mental Health is utilized for Clozaril Case Management or other scheduled, face-to-face assessment of medication compliance or efficacy. These services include obtaining the sample for necessary blood work and the laboratory results for a member by a registered nurse and subsequent evaluation of the results by the physician, PA, or APRN as necessary for the medical management of the drug Clozaril/Clozapine or other psychotropic medications which require consistent and intensive monitoring. Since this is a physician directed service, a physician, PA, or APRN must be on site and available for direct service as needed. Members may be served individually or by a group/clinic model. First, this is under a "General Medication Service" title, which list services that are not general medication... it's list SPECIFIC medication. Second, the H2010 definition has terminology such as "or other scheduled, face-to-face assessment of medication compliance or efficacy" - This section makes it sound as if ANY medication can be used for case management. Also, the definition includes - "of	Change: Clarified the definition of H2010 in the policy.

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	other psychotropic medication which require consistent and intensive monitoring" - which this statement... all psychotropic medication need consistent monitoring (even if the monitoring is every three months, that would be considered consistent." These definitions may embrace the spirit of medication that needs blood work or labs but the technically aspect seems to include all psychotropic medication. Can you please change the definition to reflect appropriately which medication are defined as this or at least list the medications this code could be used for?	
6/13/18	On behalf of Acadia and its seven clinics operating in West Virginia, Acadia thanks the Bureau for Medical Services for the opportunity to review the draft Chapter 503. Acadia has no recommended changes and commends the Bureau for following through on its commitment to make the proposed changes. Acadia appreciates the willingness of the Bureau, its Commissioner, and its staff to listen to Acadia's concerns and work cooperatively to address them.	No Change: No comment or corrections requested
6/1/18	"The initial service plan must be completed within seven days of admission to a service. The (initial) plan must be completed by the primary clinician and the member and/or member's guardian." - Does this mean we should only be doing initial plans at the time a client is admitted to a particular service, not the agency?	No Change: FAQ will be developed to clarify this and will also be reflected in trainings by the UM Contractor
6/1/18	A listing of immediate interventions to be provided along with objectives for the interventions;" - Do we need to be adding objectives to our initial plans? Currently we are only listing problems identified in the assessment.	No change in policy but will create FAQ based on the questions

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6/1/18	(pg. 48) Only qualified teams, certified by the Bureau of Behavioral Health Facilities and the Bureau for Medical Services, may provide ACT services. Certification on the team must be renewed following initial approval, at Bureau-designated intervals, of with any changes in personnel." (pg. 54) "Certification is valid for 2 years from the approval date stated on the certification letter issued by BMS." - Other providers have reported that BMS/KEPRO is not enforcing this 2-year re-certification. Do we need to prepare for re-certification? We have not gone through the re-certification process since the initial certification. We have continued to report staffing changes to BMS and have not been informed of any issues or the need to complete a re-certification process.	No Change: WV BMS reviews ACT programs on a 2-year basis and if there are issues with a provider's certification. WV BMS will notify the provider.
6/1/18	"All service plans (including updates) must be reviewed, signed, and approved by a physician within 72 hours…" Statement doesn't include psychologist or physician extender. "Documentation must contain physician's signature and credential or that of the psychologist or physician extender..." Contradicts statement in definition.	Change: Corrected

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6/1/18	Any physician that prescribes medication under the Non-Methadone Medication Assistance Treatment must have a plan in place for when they are unavailable to address medical issues or medication situations that should arise. The Physician must work with another physician that has a DEA-X." The CARA Act currently in effect till 2021 has a waiver that allows a PA or Nurse Practitioner to be given a special DEA number and prescribe OBMAT. This section of the manual contradicts Rule 12 and current SAMHSA guidelines.	Change: Corrected
6/1/18	These services include obtaining the sample for necessary blood work and the lab results for a member by a registered nurse…" LPN's can draw blood, can LPN be added for blood draws?	Change: Clarified to say by appropriate medical staff
6/1/18	The H0031 should be completed prior to the rendering of any behavioral health services." In a residential program or Crisis Unit, depending on the time of admission, there may be a need to carry out standing orders and/or observation prior to the H0031 being done.	No Change: An assessment should be completed before an individual is admitted to a Crisis Stabilization Unit
6/1/18	"WV Medicaid Behavioral Health Clinic Services are defined as services that are preventative, diagnostic, therapeutic, or palliative; that are provided on an outpatient basis, under the direction of a physician or physician extender; and are available to members to address mental illness and/or intellectual disabilities. Services must be provided by a facility that is not part of a hospital but is operated to provide medical care on an outpatient basis." If a member has a substance abuse issue, then it appears from this definition, that they can't access CRU services, so do we have to bill those services under the Rehab provider number and non-SA clients under the Clinic provider number? In contrast, WV Medicaid Behavioral Health Rehabilitation Services are defined as medical or remedial services recommended by a physician, physician extender, or licensed psychologist for reducing physical or mental disability and treating those with substance abuse issues and restoration of the member to his/her best functional level. These	No Change: Will develop an FAQ to address concerns Clinic services are a provider type based on the population served. CSU is based on the medical necessity and the diagnosis of the individual An individual with A SUD diagnosis could qualify for CSU services based on their level of need and medical necessity. The provider type number used is based on the population served. For information on SUD Waiver please see Chapter 504 SUD Waiver Services

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	services may be provided in a variety of locations such as home, community, or a residential program, but are not available within an inpatient setting. What about a clinic setting? It's not clear if the provider numbers are service based or client based. If service based, which services are considered clinic? If client based, then having to determine the correct provider number will be cumbersome, and what do we do with clients that have co-occurring issues? How does SUD Waiver fit into this scenario? Is SUD Waiver a separate provider number? Is it considered a sperate funding source? DO clients become eligible by the service or payor source? What happens if they qualify for Charity Care? Do they stay in Charity care or switch to SUD Waiver? It's very unclear how the Crisis Units will be classified and reimbursed using the ASAM criteria. If a client is admitted to the CRU for detox, will the reimbursement be different till they step "up" into CRU services? Does detox qualify as a "crisis episode"?	For Information on Charity Care please contact the Bureau for Behavioral Health and Health Facilities
6/7/18	Develop and implement a Standardized Supportive Counseling Training Curriculum Approved by BMS.	No Change: Staff must have appropriate degree, or high school diploma and documented years' experience.