# COMMENTS FOR CHAPTER 504 SUBSTANCE USE DISORDER SERVICES

# EFFECTIVE DATE: FEBRAURY 1, 2025

| Number | Date Received | Comment | Status Result |
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| **1** | 12/10/2024 | **504.15.2 PRSS ED:** As indicated in a separate email conversation, UniCare is concerned about the following language in Chapter 504.15.2, regarding the provision of Peer Recovery Support services in hospital Emergency Departments, beginning on February 1, 2025.<br><br>“Service Definition: PRSS-ED are nonclinical supports that assist members in their recovery from SUD. PRSS-ED are short-term services provided to an individual presenting at an ED with a SUD or suspected SUD. PRSS-ED Services are only billable within the ED setting. These services focus on engagement, outreach, and facilitating linkages, referrals, and warm or real-time hand-offs to community SUD providers, including community PRSS. PRSS-ED services are only provided in conjunction with the use of ED services and may not be billed for subsequent, non-emergency visits.”<br><br>“Service Eligibility Criteria: In order to receive PRSS-ED, individuals must be admitted to the ED, have a SUD or suspected SUD as a primary concern for being in the ED, and be referred to PRSS-ED by a qualified healthcare provider acting within the scope of their license.”<br><br>Specifically, if these requirements are not defined in a manner that can be clearly identified and acted upon as a part of claim adjudication, then these requirements are not enforceable and are nothing more than a guideline. For instance, does “primary concern” mean that it must be the primary diagnosis on the claim? If not, then what specifically does it mean? We believe that definition should include a list of eligible ICD-10 codes for the definition of SUD or suspected SUD. Absent which, there is no practical way to ensure that the services are not provided more broadly than they are intended to be provided. | **Change:** Language in section 504.15.2 has been amended to provide additional clarity on medical necessity for Emergency Department (ED)-Peer Recovery Support Specialist (PRSS) services. |

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| **2** | 12/12/2024 | **504.15.1 Community PRSS:** It states that prior authorization for community PRSS services is required. Is this to mean that prior authorization for the 12 units per calendar day are required or only for the additional units? | **No change:** The language specifying 12 units per calendar day for Community PRSS services is meant to indicate that prior authorization for up to 3 hours (12 units) of Community PRSS a day is allowable. Beyond that limit, additional authorization will be needed. Each managed care organization (MCO) may have a different process for prior authorization of PRSS services. |
| **3** | 12/16/2024 | **504.15.1 Community PRSS:** I would like to advocate for PRSS services to include group-based services as a billable service in section 504.15.1 – Community Peer Recovery Support Specialist Services. Group-based services are the modality of choice for the treatment of substance use disorders for decades due to the unique ability the group modality has to facilitate interpersonal learning and connection, decrease of stigma, provide an environment in which to learn and practice coping skills in vivo, and a place for the sharing of successes (Kominars, 2004, TIP 41, 2005; Yalom, 2005). PRSS have historically provided services in this modality and are proficient at doing so. It is also an efficient and cost-effective treatment modality, reaching more clients for lower cost. | **No change:** The Centers for Medicare & Medicaid Services (CMS) has not authorized the Bureau for Medical Services (BMS) to cover group PRSS services at this time. |
| **4** | 12/26/2024 | **504.15.1 Community PRSS:** We are seeing several agencies who use multiple peers with the same member in treatment with the agency. The prior version of this manual indicated that each member should have a primary PRSS who was his main supplier of PRSS services and who dealt with the member unless a random unexpected event occurred or unless the peer was working in a setting such as hospital ED or QRT teams. I feel that no member should have to see multiple differing “therapists” (support personnel/peers) during the course of the week. This does not lend itself to establishing rapport | **Change:** The language in section 504.15.1 has been updated to address the role of a primary PRSS. |

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| | | and trust between member and peer. I believe this language regarding assignment of primary peers should be restored and clarified even further in this version of the manual. | |
| **5** | 12/27/2024 | **504.18.1:** Page 21 Residential Adult Services ASAM ® Level 3.1 "The member must receive medical clearance prior to entering the program." – Medical clearance prior to entering the program is unnecessary, creates barriers for individuals to seek treatment, and clogs up emergency rooms. Medical clearance needs further defined. The need for detoxification or medical care is evaluated at the time of referral and during the nursing assessment. Furthermore, the physical examination would determine if the individual is medically stable enough to be admitted into the program. | **No change:** This section of Chapter 504 is not under review at this time. This comment will be taken into consideration when BMS updates policy for residential services at a later date. |
| **6** | 12/27/2024 | **504.18.1:** Page 22 Residential Adult Services ASAM ® Level 3.1 "Continuing Stay Criteria: Member continues to meet medical necessity for this level of care as documented by the provider of services and the treatment team. Individuals receiving RAS Level 3.1 are permitted to work no more than 20 hours a week." Most individuals leaving 3.1 level of care will need full-time employment in order to live independently in the community. The goal should be to have a tiered system within 3.1 level of care: first 30 days no employment, next 30 days begin to seek employment, last 30 days working up to full-time. The treatment requirements are still being met. The individual has the financial ability to find housing. Employment is a pathway to recovery and will prevent stagnation/boredom within the program. | **No change:** This section of Chapter 504 is not under review at this time. This comment will be taken into consideration when BMS updates policy for residential services at a later date. |
| **7** | 12/31/2024 | **504.15.1 Community PRSS:** On page 10, 504.15.1 Community Peer Recovery Support Specialist Services (Staffing Limitations line item under procedure code): Under Staffing Limitations, it states that a member may not be receiving services from more than 1 PRSS at a time, unless a crisis etc. If only one PRSS is permitted to provide services to a member, then how would we know if the person is also receiving PRSS at another agency? | **Change**: Language in section 504.15.1 has been updated to address the role of a primary PRSS. |

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| | | Suggestion: Change language to limit PRSS per member, per agency, using the following language: "A member may not be receiving services from more than one PRSS at time per agency..." | |
| **8** | 12/31/2024 | **504.15.1 Community PRSS:** On page 10, 504.15.1 Community Peer Recovery Support Specialist Services (Service Definition): Service Definition section now states that All community "PRSS services are delivered pursuant to the member's person-centered treatment plan...".<br><br>Suggestion: Conducting a full IDT treatment planning service for a member who only receives PRSS service and/or another focused care service is not currently reimbursed by Medicaid, because it is focused care. Is this required treatment plan service now going to be reimbursed even though it is not a coordinated care service? Please clarify. | **No change:** CMS guidance regarding Medicaid reimbursement for peer services requires that PRSS services be delivered pursuant to an approved plan of care. |
| **9** | 12/31/2024 | **504.15.1 Community PRSS:** On page 10, 504.15.1 Community Peer Recovery Support Specialist Services (Service Definition): The current Treatment Planning regulations also require sign off and in some instances attendance by a physician or psychologist.<br><br>Suggestion: Requiring these high level staff signatures, particularly at smaller agencies, may decrease access to the PRSS service. Please clarify whether this will this still be a requirement. | **No change:** CMS guidance regarding Medicaid reimbursement for peer services requires that PRSS services be delivered pursuant to an approved plan of care. Plans of care must align with current requirements. |
| **10** | 12/31/2024 | **504.15.1 Community PRSS:** On page 10-11, 504.15.1 Community Peer Recovery Support Specialist Services (Service Definition): In the Service Definition section, the list of allowable activities near the bottom of page 10 and top of page 11 is completely different than the allowable activities in the current PRSS services definition. Are these new activities intended to replace or supplement the current list?<br><br>Suggestion: Clarify whether these new activities listed are in addition to, or intended to replace, the activities listed on pp. 25-26 of the current regulation. | **No change:** Proposed language in section 504.15.1 will replace former 504.15.1 language when the rule is finalized**.** |

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| **11** | 12/31/2024 | **504.15.1 Community PRSS:** On page 11, 504.15.1 Community Peer Recovery Support Specialist Services (Role Description section): Role Description section, last paragraph, says the treatment plan should be reviewed every 90 days and the member's recovery plan should be reviewed every 30 days. Having 2 different types of plans on differing schedules is confusing, overly burdensome, and ripe for errors. Currently we do a recovery plan every 90 days which we believe is an effective interval.<br><br>Suggestion: Keep both the IDT and the recovery plan reviewable every 90 days. | **Change:** Section 504.15.1 has been updated to clarify recovery plan requirements. |
| **12** | 12/31/2024 | **504.15.1 Community PRSS:** On page 12, 504.15.1 Community Peer Recovery Support Specialist Services (Limitations/Exclusions): Under Limitations/Exclusions section it notes "PRSS may not administer drug screens for members." We are interpreting this, like others in this list, as meaning the PRSS cannot bill PRSS service for administering the urine drug screen.<br><br>Suggestion: If our interpretation is correct, then we suggest the language be changed to "PRSS may not bill for administering drug screens for members". If our interpretation is not correct and the statement is taken at face value, this is a concern. Administering urine drug screens is part of the job duties at every SUD treatment center. As the draft currently reads, PRSS may provide the more complex certified PRSS services defined here but in the next paragraph are not allowed to administer a simple drug screen that anyone can do. | **Change:** Section 504.15.1 has been updated to clarify the PRSS role in drug screening. |
| **13** | 12/31/2024 | **504.15.1 Community PRSS:** On page 14, 504.15.1 Community Peer Recovery Support Specialist Services (Recovery Plan): Recovery Plan section, last sentence says "the recovery plan should be reviewed at least every 30 days and must be signed and reviewed / updated in conjunction with the member's treatment plan every 90 days. Having 2 different types of plans on differing schedules is confusing, overly | **Change:** Section 504.15.1 has been updated to clarify recovery plan requirements**.** |

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| | | burdensome and ripe for errors. Currently we do a recovery plan every 90 days which we believe is an effective interval.<br><br>Suggestion: Keep both the IDT and the recovery plan reviewable every 90 days. | |
| **14** | 1/2/2025 | **504.15.1 Community PRSS:** On page 11, 504.15.1: Prior authorization for community PRSS services is required. Members may receive a maximum of three hours (12 units) of services per calendar day. Additional units of services may be approved as an exception with documentation of medical necessity. Providers must request prior authorization for any additional units of services provided over the 12-unit limit. Members requiring consistent or consecutive daily use of large number of units in any four-week period must be reassessed for the need for a higher level of care. This assessment should be documented in the members' file and conducted pursuant to Section 503.15, Peer Recovery Support Specialist Services. Members must have their treatment plan reviewed at least every 90 days. The member's recovery plan should be reviewed at least every 30 days. On page 11, 504. 15.1: ***The section that is referenced in this section 503.15 is not the correct section that is referenced*** | **Change:** Section 504.15.1 has been updated to correct this reference. |
| **15** | 1/2/2025 | **504.18 RAS:** Both 3.5 and 3.1 sections reference that the member has to have medical clearance prior to entering the program. This doesn't feel necessary at this level of care considering the clients would not be in active withdrawal upon admission. We get the client in within 72 hours for an APO and we try to also get them in to see a PCP within that time frame so that if there were medical issues happening, we can get them addressed quickly. | **No change:** This section of Chapter 504 is not under review at this time. This comment will be taken into consideration when BMS updates policy for residential services at a later date. |
| **16** | 1/2/2025 | **504.18.1 RAS:** On page 21, Residential Adult Services ASAM ® Level 3.1 504.18.1: The Continuing stay criteria states that the client is not permitted to work no more than 20 hours per week. With the rising costs of rent and utilities, if clients are limited to how much they can work, and with the short time span the insurances allow of to keep | **No change:** This section of Chapter 504 is not under review at this time. This comment will be taken into consideration when BMS updates policy for residential services at a later date. |

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| | | clients in residential treatment, this creates a financial barrier to have clients appropriate set up for housing costs when they leave treatment. | |
| **17** | 1/3/2025 | **504.15.1 Community PRSS:** Group Peer Support Services Coverage: Currently, group peer support services are not a covered service. However, we believe that offering group services provided by certified Peer Support Specialists would provide several key benefits to our members. These benefits include creating a safe environment where members can openly express their feelings and relate to one another, ultimately reducing loneliness and stigma.<br>Additionally, group services can increase social connection, self-esteem, and motivation among members. Group services are currently covered by Medicaid in several states, including Kentucky, Virginia, and North Carolina. We strongly advocate for West Virginia to consider adding group services, facilitated by a certified Peer Support Specialist, to the 504 Manual. | **No change:** CMS has not authorized BMS to cover group PRSS services. |
| **18** | 1/3/2025 | **504.15.1 Community PRSS:** Peer Recovery Support for Mental Health: In 2025, a certification specifically for Mental Health Peer Recovery will be introduced, mirroring the Substance Abuse Peer Support certification. We would like to suggest that the Manual include this as an addition to the Peer Support services section. | **No change:** CMS has not authorized BMS to cover PRSS services for mental health needs. |
| **19** | 1/3/2025 | **504.15.1 Community PRSS:** Increasing Cap for PRSS in Outpatient Facilities: Currently, the cap for the number of patients per Peer Recovery Support Specialist (PRSS) in outpatient facilities is limited to 20. Although, this does seem to be an appropriate caseload compared to other States, we would like to suggest to increase the cap to a minimum of 25 to accommodate the growing demand for these essential services. | **No change:** The language regarding maximum caseloads for PRSS is no longer in the manual. |
| **20** | 1/5/2025 | **504:** Meaningful and impactful action should be taken to address years of chronic underfunding in the SUD treatment system and to ensure a provider network that is able to administer the full continuum of care across the behavioral healthcare spectrum. Uncompetitive reimbursement rates prohibit providers from recruiting and retaining appropriate staffing to serve our patients and force us to limit services | **No change.** |

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| | | and turn away patients in need of care. We urge the Department to make investments in the Medicaid system for SUD providers to better align West Virginia's SUD treatment reimbursement rates with those of other states. In order to address the effects of the opioid epidemic, treat those affected by substance use disorder, and address years of chronic underfunding in the treatment system, West Virginia should increase Medicaid reimbursement rates for residential and outpatient SUD treatment services through remaining pandemic relief funds, the state's opioid litigation settlement dollars, federal matching funds, and general revenue. This would include the adoption of transparent and streamlined rate setting processes, annual cost of living adjustments ("COLAs"), as well as regular rate studies to ensure the state's reimbursement infrastructure remains competitive with industry standards, labor market conditions, and surrounding states. These rates should be sufficient to align directly with the staffing and regulatory requirements outlined in the ASAM levels of care. We also recommend better alignment between BMS and the Office of Health Facility Licensure & Certification ("OHFLAC") regarding requests for waivers of regulatory requirements. Currently, BMS is much more restrictive and should adopt a commonsense and fair waiver and appeals process to allow providers acting in good faith to waiver a regulation with stipulations. | |
| **21** | 1/5/2025 | **504.1: Page 4 Member Eligibility:** If a Medicaid beneficiary is dually-eligible and has secondary insurance through Medicare, Medicaid will not pay for their service. Medicaid is always the payer of last resort, so in order to Medicaid to pay for these clients, they must first receive a denial from Medicare. The issue is that for the vast majority of settings and levels of care, Medicare does not cover or reimburse for SUD treatment services. Thus, it is not possible to obtain the required Medicare denial in order to bill Medicaid because providers are ineligible to enroll in Medicare in the first place. This Catch-22 requires resolution through federal legislative and regulatory means but has direct implication on coverage and reimbursement for client care in | **No change:** Changes to Medicare and requests for State Opioid Response (SOR) grant funding regulation are outside the scope of this rule change. |

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| | | states like West Virginia. We recommend West Virginia request increased funding through State Opioid Response ("SOR") Grants to address this gap in coverage. | |
| **22** | 1/5/2025 | **504.3.1 Enrollment Requirements: CBHC and LBHC Administration** Pyramid Healthcare supports West Virginia's recent efforts to require providers in the state be accredited by a nationally recognized body such as the Commission on Accreditation of Rehabilitation Facilities ("CARF"). This certification demonstrates a program's ability to deliver a specific level of care in a safe and high-quality manner. We encourage states to create pathways such as deemed state licensure status for facilities that maintain third party accreditation from robust third party bodies like CARF. Specifically, agencies that have received three-year (as opposed to one-year) accreditation from CARF have demonstrated significant compliance with rigorous standards.<br><br>**504.3.2 Enrollment Requirements: Staff Qualifications:** Experience in lieu of a degree should count toward eligibility and qualifications for various positions, which is especially important in behavioral health fields.<br>Of note, we wanted to flag the reference to psychologists in this section since they cannot perform medical care. They can do some clinical assessments for a patient but they cannot do anything medically per their scope of practice. Perhaps it was intended to reference psychiatrists since the subsequent paragraph references psychiatric certifications. | **No change:** This section of Chapter 504 is not under review at this time. This comment will be taken into consideration when BMS updates policy for CBHC and LBHC Administration at a later date. |
| **23** | 1/5/2025 | **504.4 Fingerprint-Based Background Checks:** While we have no comments or feedback at this time regarding the standard practice for fingerprint-based background checks, we do have a number of comments regarding challenges and proposed changes to the variance process. We like and support a strong variance process but believe that West Virginia's current system takes too long and excessively holds up the process. It should move faster whereas it can | **No change:** This section of Chapter 504 is not under review at this time. This comment will be taken into consideration when BMS updates policy for background checks at a later date. |

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| | | currently take up to 45 days to approve a variance once a lot of materials and information have been submitted. The variance process should also be revised to make sure people can actually make it through the door without the process being either too permissive or overly restrictive by prohibiting someone from being approved for a variance if they have met their relevant probation requirements. | |
| **24** | 1/5/2025 | **504.4.1 Variance For Peer Recovery Support Specialist:** See above for our comments regarding the need for reforms to the variance process. This is especially important for peer recovery support specialists. The very thing that makes peers and CRS crucial to the treatment process—lived experience with mental health and substance use disorders—often puts them in need of a variance because their history may contain criminal justice charges tied to their addiction and thus requiring them to submit the variance. Much attention has been paid to roles such as peer support specialists and certified recovery specialists in the SUD treatment space. These roles are, of course, essential in helping new clients obtain and sustain long-term recovery as a result of the shared life experiences and common bond shared between peer and client. It has the added benefit, however, of creating pathways into the healthcare profession for people stable in their recovery and provides a lifeline and opportunities for career advancement or further education. Since it is not uncommon for someone recovery from SUD to have had interactions with law enforcement or conviction and imprisonment, it is important for West Virginia to have common sense laws around barrier crimes that enable people to reenter the workforce and expand access to employment while also providing liability protections to the employers that take on the risk of employing this population. | **No change:** This section of Chapter 504 is not under review at this time. This commenter's insights will be taken into consideration when BMS updates policy for variances for PRSS at a later date. |
| **25** | 1/5/2025 | **504.5 Clinical Supervision:** We request that West Virginia adopt more streamlines timelines and processes for approval of clinical licenses. There have been delays in licensing Pyramid Healthcare staff such as clinical directors in order for them to provide clinical supervision and oversight for therapists and other clinicians, which | **No change:** This section of Chapter 504 is not under review at this time. This comment will be taken into consideration when BMS |

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| | | negatively affects our ability to treat West Virginia residents. One specific example is the licensed professional counselor ("LPC") certification process takes months because applicants have to wait for the next board meeting every 2-3 months where applicants are approved or denied en masse. Thus, if an applicant is denied for a minor technical issue that is easily and quickly addressed, the applicant still has to wait several more months for the next board meeting. We request West Virginia adopt a real time licensure approval process be adopted similar to what is in place in Maryland, which speeds up access to care. | updates policy for clinical supervision at a later date. |
| **26** | 1/5/2025 | **504.7 Provider Reviews:** BMS' Medicaid regulations in Chapter 503 conflict with those of the OHFLAC and the U.S. Centers for Medicare and Medicaid Services ("CMS") with regard to the number of members a clinician can oversee in a group outpatient setting. The rules should be streamlined to ensure consistency across regulations. Although technically an outpatient-specific problem, it turns out that the residential regulations in turn reference the outpatient regulations, which makes it an issue regardless of setting. The current standards dictate that a group setting consists of only up to 12 clients.2 If a clinician is only allowed to have 12 clients and there are 13 clients in the group, then providers are required to have two clinicians staffing that group therapy session, doubling our staffing needs and our costs. It is actually not just the cap of 12 on the number of participants in a group therapy session, state regulations limit total caseload for a clinician at 12. This means we need to add new staff in order to treat our 13th client, 25th client, 37th client, etc. This puts the standard and the cost on providers. This approach is not adapted to the modern needs of the SUD treatment system and stymies growth and efficiency as well as our ability to sustain operations. Furthermore, this is not the standard in other states in which Pyramid Healthcare operates SUD treatment programs. Instead, other states have requirements for each level of care that is customized and appropriate to the billable service. | **No change:** This comment will be taken into consideration for future policy updates, as applicable to Chapter 503. |

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| **27** | 1/5/2025 | **504.9 Other Administrative Requirements:** We reiterate our comments about the incompatibility of Chapter 503 to residential treatment programs and the need to develop more customized guidelines that reflect the delivery of care to SUD clients in residential settings rather than requiring residential providers to adhere to guidelines written for outpatient treatment. | **No change:** This section of Chapter 504 is not under review at this time. This comment will be taken into consideration when BMS updates policy for administrative requirements at a later date. |
| **28** | 1/5/2025 | **504.11 Documentation:** We reiterate our comments about the incompatibility of Chapter 503 to residential treatment programs and the need to develop more customized guidelines that reflect the delivery of care to SUD clients in residential settings rather than requiring residential providers to adhere to guidelines written for outpatient treatment. This is particularly a pain point with the restriction on the size of a group therapy session to 12 clients even in residential treatment settings. Documentation leads to billing. There should be modifiers for the different levels of care to reflect that staffing requirements should be different as well as the number of people in the group or the certification levels of the staff or the staffing to client ratio.<br>West Virginia also continues to adhere to outdated treatment team methodologies in the Chapter 503 regulations providing further need for guidelines to be further broken out by level of care rather than applied across all levels of care. The process becomes very granular and overly time consuming for staff. The intention is well placed—to provide better care—but the result is the clinical treatment team being regularly pulled out of direct client care in order to focus on administrative procedures. Specifically, the required weekly treatment planning reviews for every client are onerous, burdensome, and takes valuable staff time away from face-to-face client care. The inevitable result is a case management conversation with too many people in the room and with the clinical director essentially having to sign off on upwards of 100 unique client charts every week. the process as it stands today costs the system a lot of money with no verifiable outcome and no benefit to client care. While we of course agree that it | **No change:** This section of Chapter 504 is not under review at this time. This comment will be taken into consideration when BMS updates policy for documentation at a later date. |

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| | | is important for a licensed person to verify that a client received treatment planning done and was part of the treatment planning process, that can better be accomplished through the existing treatment team meetings. | |
| **29** | 1/5/2025 | **504.12:** SBIRT ASAM® Level 0.5 Early Intervention 504.12.1 Mental Health Assessment by Non-Physician: We reiterate our comments about the incompatibility of Chapter 503 to residential treatment programs and the need to develop more customized guidelines that reflect the delivery of care to SUD clients in residential settings rather than requiring residential providers to adhere to guidelines written for outpatient treatment.<br>Additional clarification or amendment is needed with regard to the maximum of four mental health assessments per year by a non-physician for people with complex behavioral health needs and two for noncomplex patients. Anyone seeking treatment for ASAM 3.7 level of care are—by definition—complex. In addition, the limit of four per year is by patient and not by provider. It is highly possible that a client seeking ASAM 3.7 level of care may need or have received more than four assessments during the course of the year by multiple providers throughout the state who should not be punished for treating that patient.<br>**504.12.2 Psychiatric Diagnostic Evaluation (No Medical Services):** We request more clarity to differentiate between services described in Section 504.12.2 and Section 504.12.1. Specifically, which of these describe the level of care assessment ("LOCA") and which personnel are authorized to conduct this service. This is an important question to answer because most payers would not pay for a non-licensed person to do a billable service. | **No change:** These sections of Chapter 504 now refer to 503 policy and are not under review at this time. This comment will be taken into consideration for future policy updates and/or policy updates in Chapter 503. |
| **30** | 1/5/2025 | **504.15 PRSS:** There are a lot of requirements for peers and an excessive degree of administrative burden and regulatory requirements. The hurdles and barriers to entry for people wishing to become a peer recovery support specialist are daunting. While it is important to have criteria to ensure both our clients' safety as well as | **No change:** BMS aligns with the West Virginia Certification Board for Addiction & Prevention Professionals (WVCBAPP) requirements. |

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| | | ensure the peer's own recovery is not jeopardized, the current threshold of time period in recovery plus service hours before someone is allowed to sit for the exam is too high.<br>Additionally, while peer services are billable under Medicaid in outpatient settings, it is currently not covered in residential settings. We urge these services be billable in residential settings as well. It is perhaps even more important to employ and utilize peers in residential settings given the increased the complexity of a patient only shortly removed from their active addiction and early in their recovery journey. This leads to an increased likelihood of wanting to leave to return to their addiction—right when a peer recovery support specialist is arguably most needed in order to talk about their experiences going through the same situations and helping those clients to remain in treatment and continue on the pathway to sustained recovery. | |
| **31** | 1/5/2025 | **504.15.1 Community PRSS:** We reiterate our comments above in 504.15 regarding peer recovery support specialist services. | **No change:** BMS aligns with the WVCBAPP requirements for PRSS. |
| **32** | 1/5/2025 | **504.16 Intensive Outpatient Services:** We reiterate our concerns that West Virginia does not ever allow a group to contain more than 12 clients under any conditions, which places extreme burdens on staffing requirements when adding a 13th client to a program essentially doubles programs' employment needs.<br>Additionally, it is essential to create and maintain a full continuum of care and provider networks for residential and outpatient SUD facilities across the State to reduce fatal and nonfatal overdoses. This includes access to treatment, transition out of treatment, and transition into the workforce with continued support through services such as detox/withdrawal management, residential treatment, outpatient treatment, recovery residences and recovery housing, peer recovery support specialists, and independent living with structured housing. To increase the capacity of recovery housing in West Virginia, we must provide long-term, sustainable funding, resources, and training to increase the capacity of recovery residences and the appropriate use | **No change:** This section of Chapter 504 is not under review at this time. This comment will be taken under consideration when BMS updates policy for residential services at a later date. |

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| | | of recovery housing. States such as Virginia and New Jersey allow a client to receive recovery housing or low-intensity residential services such as ASAM Level 3.1 simultaneously as they do PHP or IOP services. This would streamline the continuum of care and ensure a smooth handoff between acuity levels if providers are able to bill ASAM 3.1 and PHP in the first month and then step down the client to an IOP level of care while continuing to offer ASAM 3.1 residential support. In addition, the ability to be able to provide and bill for wrap-around services such as transportation, peer support services, and case management support ensures safe reentry into the community and sustainable recovery for those struggling with SUD needs. | |
| **33** | 1/5/2025 | **504.17 Partial Hospitalization Program:** It is important for the Department to understand that partial hospitalization programs ("PHPs") do not just happen in hospital settings. There are freestanding, independent PHP programs that do not operate in a hospital setting and, thus, there may be requirements in Section 510.7 titled "Acute Care Hospital Outpatient Services" that are not applicable and should not be enforced artificially on these programs.<br>We also reiterate our concerns that West Virginia does not ever allow a group to contain more than 12 clients under any conditions, which places extreme burdens on staffing requirements when adding a 13th client to a program essentially doubles programs' employment needs. We refer to our comments in the previous section with regard to requesting to be able to "stack" PHP and IOP services with ASAM Level 3.1 or recovery housing services similar to what is offered in Virginia. | **No change:** This section of Chapter 504 is not under review at this time. This comment will be taken under consideration when BMS updates policy for residential services at a later date. |
| **34** | 1/5/2025 | **504.18.1:** Residential Adult Services ASAM ® Level 3.1: We reiterate our comments about the incompatibility of Chapter 503 to residential treatment programs and the need to develop more customized guidelines that reflect the delivery of care to SUD clients in residential settings rather than requiring residential providers to adhere to guidelines written for outpatient treatment. We have one clarification regarding the Support Systems language, which requires literacy | **No change:** This section of Chapter 504 is not under review at this time. This comment will be taken under consideration when BMS makes policy updates to residential services at a later point. |

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| | | training and adult education services. While these items are important, it should be based on the client's individual needs rather than a blanket requirement since not every graduating client needs to pursue their GED or otherwise go back to school even though many certainly do.<br>Given the impending ASAM 4th edition and the increase in clinical hours requiring additional provider staff, we reiterate that there should be corresponding reimbursement rate increases for providers to offset the increase administrative burden and staff compliance time. | |
| **35** | 1/5/2025 | **504.18.2:** Residential Adult Services ASAM ® Level 3.3: We reiterate our comments about the incompatibility of Chapter 503 to residential treatment programs and the need to develop more customized guidelines that reflect the delivery of care to SUD clients in residential settings rather than requiring residential providers to adhere to guidelines written for outpatient treatment.<br>We have one clarification regarding the Support Systems language, which requires literacy training and adult education services. While these items are important, it should be based on the client's individual needs rather than a blanket requirement since not every graduating client needs to pursue their GED or otherwise go back to school even though many certainly do.<br>Given the impending ASAM 4th edition and the increase in clinical hours requiring additional provider staff, we reiterate that there should be corresponding reimbursement rate increases for providers to offset the increase administrative burden and staff compliance time. | **No change:** This section of Chapter 504 is not under review at this time. This comment will be taken under consideration when BMS makes policy updates to residential services at a later point. |
| **36** | 1/5/2025 | **504.18.3:** Residential Adult Services ASAM ® Level 3.5: We reiterate our comments about the incompatibility of Chapter 503 to residential treatment programs and the need to develop more customized guidelines that reflect the delivery of care to SUD clients in residential settings rather than requiring residential providers to adhere to guidelines written for outpatient treatment. Specifically, regarding the restriction of group sizes to only 12 clients, the process does not currently allow caveats for extenuating circumstances or | **No change:** This section of Chapter 504 is not under review at this time. This comment will be taken under consideration when BMS makes policy updates to residential services at a later point. |

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| | | unprecedented challenges such as the COVID-19 pandemic. The guidelines should be specific to the level of care. A limit of 12 clients may make sense for outpatient care where providers are billing for the specific service of group therapy. Residential treatment, however, is a bundled payment for all services so payers are not specifically paying for a group therapy session.<br><br>We have one comment regarding the sentence "The length of treatment depends on an individual's progress." In our experience, insurance companies are not consistent in application of this standard. The standard should be based on whether the client is meeting the medical necessity requirements for that level of care rather than an arbitrary 28 days.<br>Given the impending ASAM 4th edition and the increase in clinical hours requiring additional provider staff, we reiterate that there should be corresponding reimbursement rate increases for providers to offset the increase administrative burden and staff compliance time. | |
| **37** | 1/5/2025 | **504.18.4:** Residential Adult Services ASAM® Level 3.7: We reiterate our comments about the incompatibility of Chapter 503 to residential treatment programs and the need to develop more customized guidelines that reflect the delivery of care to SUD clients in residential settings rather than requiring residential providers to adhere to guidelines written for outpatient treatment.<br><br>Under the Support Systems paragraph, we urge amendments be made to the staffing requirements. More flexibility is needed on the intake to allow for the participating of licensed practical nurses ("LPNs") not just registered nurses ("RNs"). We do, however, support the stipulation that although an LPN can conduct the level of care assessment ("LOCA"), an RN will co-sign and review the plan within a certain time period. We believe that similarly while conducting the 24 hour medical history and physical ("H&P"), that there is room to explore increased collaboration between RNs and LPNs to allow the | **No change:** This section of Chapter 504 is not under review at this time. This comment will be taken under consideration when BMS makes policy updates to residential services at a later point. |

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| | | LPN to collaborate within their scope of practice with an RN working within their scope of practice who is onsite to co-sign and manage the assessment. We do not mean to suggest that authority to diagnose should not remain in the hands of a licensed clinician. Given the impending ASAM 4th edition and the increase in clinical hours requiring additional provider staff, we reiterate that there should be corresponding reimbursement rate increases for providers to offset the increase administrative burden and staff compliance time. | |
| **38** | 1/5/2025 | **504.23 Prior Authorization:** Pyramid Healthcare supports efforts to reduce or remove any and all barriers to treatment and access to care. We recommend the Department institute consistent prior authorization approval periods since all of these payers serve Medicaid. Currently, each managed care organization (MCO) utilizes its own time period ranging from one week to 28 days. In addition, some MCOs require the ASAM forms to be submitted within 24 hours while others require a 48-hour deadline. We request the Department institute a standardized time period of 24-48 business hours during weekdays or 72 calendar hours on weekends to lessen the burden on providers in meet this administrative burden when access to utilization review or licensed clinical teams may be more limited during weekend or overnight hours. | **No change:** This section of Chapter 504 is not under review at this time. This comment will be taken into consideration when BMS updates policy for prior authorization at a later date. |
| **39** | 1/5/2025 | **Glossary - Advanced Alcohol and Drug Counselor (AADC):** While we, of course, support the inclusion of AADCs in the regulations, it is worth noting that there are, in practice, few if any AADCs available for hire in West Virginia. State law and practice creates barriers to entry for this certification level that disincentivize people from pursuing this pathway. The requirements to obtain the certification are unrealistic for many interested persons when other licensure levels offer substantially similar scopes of practice and similar responsibilities. There are also logistical barriers such as requiring a separate test and exam as well as additional fees beyond those already paid as part of similar licensure processes. West Virginia should either lower barriers to entry to AADC or update regulatory guidance to bolster authority for other similar licensure levels. | **No change:** This comment will be taken under consideration. |

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| **40** | 1/5/2024 | **Glossary - Human Services Degree:** We appreciate an expansive definition of this degree to allow multiple avenues into the human services field. This broader definition is more favorable than more restrictive state definitions like those found in Virginia. | **No change.** |
| **41** | 1/5/2024 | **Glossary – Incident:** The Program Manual for Chapter 504 merely defines an incident as "[a]ny unusual event occurring to a member that needs to be recorded and investigated for risk management or Quality Improvement purposes." This is too vague as is incident reporting in general in West Virginia. We recommend the creation of incident categories or a spectrum to account for the fact that some incidents are more extreme than others, such as a distinction between "sentinel" and "basic" incidents. This would create an opportunity for the state to develop a formalized standard process outlining responsibilities and required information. Currently, the only way to report sentinel or highly critical events is to inform the relevant managed care organization ("MCO") which is challenging because each MCO has its own customized reporting requirements. Instead, a consistent and standardized formal standard should be developed. | **No change:** This comment will be taken under consideration for future policy updates. |
| **42** | 1/5/2024 | **Glossary - Licensed Professional Counselor (LPC)** Chapter 504 does not current contain a definition of Licensed Professional Counselor ("LPC") in the glossary and only makes one other reference in the manual. We recommend the addition of a definition to indicate that LPCs are vital in the SUD treatment continuum and are qualified professionals able to offer certain services. | **Change:** An LPC definition has been added to the glossary of the manual. |
| **43** | 1/5/2024 | **Glossary - Medical Clearance** This is one of the intake criteria for ASAM levels 3.7, 3.5, and 3.1 within BMS regulations. More clarification is needed regarding who is the person making this determination. We believe it should not just be restricted to an RN but should also include an LPN. We propose the following revised definition: "Medical clearance means, based on an assessment of relevant medical staff working within scope and licensure (e.g., RNs, LPNs, etc.) it has been determined the patient is stable enough to | **No change:** This comment will be taken under consideration for future policy updates. |

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| | | benefit from the program and is not likely to experience medical complications that could prove harmful." In other states, LPNs are able to triage patients and perform nursing assessments so long as an RN is supervising them. In West Virginia, RNs must perform both triage and nursing assessments. RNs are both more expensive to employ and more difficult to hire and retain. Instead, West Virginia should extend an LPN's ability to triage and assess so long as they are doing it with the supervision of an RN who is able to sign off on the assessment. | |
| **44** | 1/6/2025 | **504.15.1 Community PRSS:** Community Peer Recovery Support Specialist Services Page 13, the two years in recovery has been removed, is this an oversight or no longer a requirement? | **No change:** BMS aligns with WVCBAPP requirements. |
| **45** | 1/6/2025 | **504.15.1 Community PRSS:** Community Peer Recovery Support Specialist Services Page 10 states "All community PRSS services are delivered pursuant to the member's person-centered treatment plan. " The service code in Chapter 503 is "Service Planning" and we had been asked years ago to utilize this terminology, is this changing? | **Change:** Language in section 504.15.1 has been updated to align with 503.16 service planning terminology. |
| **46** | 1/6/2025 | **504.15.1 Community PRSS:** Community Peer Recovery Support Specialist Services Page 13 – Supervision- does not state Master's level clinician? Is this no longer the requirement? If it is, we recommend adding it. | **No change:** BMS aligns with WVCBAPP supervision requirements. |
| **47** | 1/6/2025 | **504.15.2 PRSS-ED:** Peer Recovery Support Specialist Emergency Department Services Page 14- NOTE: "More than one type of service and/or activity may be provided at any (one) meeting."- Does each activity need to be separated out by start and stop time? If so, include that. | **No change:** Each PRSS activity does not need to be separated out by a start and stop time. The overall PRSS service start/stop time must be included in documentation. |
| **48** | 1/6/2025 | **504.15.2 PRSS ED:** Peer Recovery Support Specialist Emergency Department Services Page 14- Recovery Plan- "A recovery plan/strategy shall be developed as part of the member's treatment plan to reflect recovery goals and objectives, and the specific services and supports the PRSS will provide to support the member in | **Change:** Language in section 504.15.2 has been updated to clarify recovery plan requirements. |

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| | | achieving them. If clinical services have been terminated but recovery services continue, a recovery plan/strategy is developed to reflect recovery goals and objectives. This should include determining wellness markers, the member's hopes and short and long-term recovery goals, recognizing triggers, determining warning signs and managing crisis. PRSS should be able to recognize signs of relapse and assist in making appropriate referrals to clinical services if a relapse occurs. This recovery plan should be reviewed at least every 30 days and must be signed and reviewed/ updated in conjunction with the member's treatment plan every 90 days." –" recovery plan/strategy"- Does this mean they will be required to complete both "Service/Treatment Plan" and a Recovery Plan? We recommend including who must participate in the Recovery Plan? Historically it was the member, PRSS and the Master's level supervisor. We would recommend stating who needs to be present and that they must include signature with credentials, date and start/stop times for each attendee. 503.16 requirements- if focused care? | |
| **49** | 1/6/2025 | **504.15.2 PRSS ED:** Peer Recovery Support Specialist Emergency Department Services Page 16- Supervision credential required for outside Community PRSS, i.e., PRSS-ED? | **No change:** BMS aligns with WVCBAPP requirements for supervision. |
| **50** | 1/6/2025 | **504.18:** Residential Adult Services Page 18- "The record must contain a written physician's/physician extender's order authorizing RAS and the member's individualized service plan and level of care" We suggest adding the timeframe for which the Physician's order needs to be completed. In the past, it was indicated that it needed to be completed within 24 hours. We also would recommend including that if the orders are verbally communicated the clinician receiving the verbal orders must sign with credentials and identify as "verbal orders" and then the physician/extender must sign off. | **No change:** This section of Chapter 504 is not under review at this time. This comment will be taken under consideration when BMS makes policy updates to residential services at a later point. |
| **51** | 1/6/2025 | **504.18:** Residential Adult Services Page 19- Within 72 hours of admission, a service plan must be developed and reviewed at least every seven calendar days thereafter, or when a critical juncture takes place;-- Should the plan be developed sooner for 3.7 since 72 hours | **No change:** This section of Chapter 504 is not under review at this time. This comment will be taken under consideration when |

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| | | could be the entire length of stay? Also, we would recommend that Service Plan Reviews must meet requirements signatory requirements of Chapter 503. | BMS makes policy updates to residential services at a later point. |
| **52** | 1/6/2025 | **504.18:** Residential Adult Services Page 19- Service Planning: LBHCs, CCBHCs, and CBHCs must follow Service Planning requirements as described in BMS Chapter 503.15. This is the wrong link… this is Psychological Testing. Should be 503.16 Service Planning Requirements | **Change:** This has been updated to correct this reference. |
| **53** | 1/6/2025 | **504.18:** Residential Adult Services Page 21- "MAT is available to members in conjunction with their residential treatment. Please see Chapter 503<br>Licensed Behavioral Health Centers (LBHC) and Section 519.22.2 (pending updates) for MAT in the residential setting. If a member is in a Residential Setting, they must still meet the criteria and policy requirements stated in<br>Chapters 503, Licensed Behavioral Health Centers and 519.22, Mental Health Counseling and Substance Abuse Treatment. Is this methadone only or Suboxone/Vivitrol? Can they bill Suboxone med management (E& M codes) and MAT therapy outside of the SUD RAS per diem? Does it differ within levels? | **No change:** This section of Chapter 504 is not under review at this time. This comment will be taken under consideration when BMS makes policy updates to residential services at a later point. |
| **54** | 1/6/2025 | **504.18 RAS:** Residential Adult Services Page 21 "Admission Criteria: The following admission criteria must be met: Referral received by physician, physician extender, or provider of services;" Although already stated, we would recommend stating "For all levels the physician order form must be completed within 24 hours signed and dated by the physician/extender—we would recommend adding this under each level. | **No change:** This section of Chapter 504 is not under review at this time. This comment will be taken under consideration when BMS makes policy updates to residential services at a later point. |
| **55** | 1/6/2025 | **504.18 RAS:** Residential Adult Services Page 22 "Program Requirements: This service level must have a 24-hour structure with appropriately trained staff. The program must consist of at least five hours of clinical service per week in addition to structural supports in the residential setting and should be designed to help a member complete their goals and objectives to step down to outpatient level of | **No change:** This section of Chapter 504 is not under review at this time. This comment will be taken under consideration when BMS makes policy updates to residential services at a later point. |

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| | | care. Clinical services must meet service definition and service documentation requirements." – Might want to add that the staff need to be onsite 24hours as well—we have run into this issue during the recertification and it was said that the manual doesn't specify that it has to be onsite | |
| **56** | 1/6/2025 | **504.18.2:** Residential Adult Services ASAM ® Level 3.3 Page 23—is SUD RAS 3.3 staying? Also, all levels still include the old amount of hours? Will you revise that later? | **No change:** This section of Chapter 504 is not under review at this time. This comment will be taken under consideration when BMS makes policy updates to residential services at a later point. |
| **57** | 1/6/2025 | **504.19.2:** ASAM ® Level 3.2 Withdrawal Management Page 32 Service Exclusion- We would recommend adding copied or boilerplate language to the service exclusion list. This is the language in 503 "Copied or boilerplate language in documentation will not be reviewed and will cause dis-allowment." | **No change:** This section of Chapter 504 is not under review at this time. |