

COMMENT LOG

Chapter: 504 Substance Use Disorder Services
Public Comment Period: August 6, 2025, to September 6, 2025

Comment Number	Date Received	Comment	Action
1	8/8/2025	504.15.1 (page 10): The document states that a member cannot receive services from “more than one PRSS at a time”. Could this be rephrased to state: cannot receive services billed by more than one PRSS at the same time? You do a great job of clarifying later that the peers should be assigned as primary and unless something unusual arises, that peer is the member’s assigned support person and that only one agency at a time can provide PRSS services to a member.	Change: BMS is adopting the proposed language change to clarify this.
2	8/8/2025	504.15.1 (page 14): Recovery plans are designed to be flexible, frequently modified documents. To require that any changes be brought to the entire clinical team for approval reduces the flexibility and the utility of the document. Would suggest discussion with Dave Sanders on this issue. You may want to consider allowing/not allowing billing of H0032 for recovery plan reviews q 30 days (my thought would be it would not be allowed, but either way, it should probably be specified).	Change: A change has been made clarifying how the recovery plan should be used and reviewed.
3	8/8/2025	504.15: Inclusion of category of PRSS service in the requirements for PRSS activity note documentation is not useful and will result in more overreliance on EMR copy and pasting. Formats for notes by peers should be simple and straightforward. PRSS ED documentation requirements when read as written simply requires a category without a description of what was actually discussed rather than the content of the activity/encounter. All PRSS notes should contain a section for response to the intervention, particularly in the ED (example: member was given contact information for an inpatient detoxification program and urged to consider admission, responded by taking the information and stating that he would “think about it”.)	Change: BMS updated language in policy, keeping the category but adopting emphasis that notes need to be individualized and describe impact of intervention.
4	8/8/2025	504.15.1 (page 11): While we appreciate the attempt to prevent repeated high utilization of PRSS units, it might be helpful to define what constitutes high utilization. We see many PRSS associated with recovery residences billing for four to eight units a day four to five days a week for stable individuals. Perhaps the language could add as a definition of high utilization: frequent rates of billing over 8 units or daily four to eight units of billing for four to five consecutive days each week without a description of the medical necessity for frequency of service.	No change: The policy currently indicates that members requiring consistent or consecutive daily use of large number of units in any four-week period must be reassessed due to the need for a higher level of care is currently in policy. If PRSS services are found to no longer be medically

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			necessary, the MCO will deny additional units.
5	8/8/2025	504.18 (page 19): RAS program director requirements are confusing and contradictory. Is the program director (preferred) meant to be a licensed clinician? And the non licensed is the less preferred option but with more related required experience?	No change: The licensed clinician is BMS' preferred option. The criteria specified in policy aligns with ASAM 4 th edition criteria for the program director of a residential.
6	8/8/2025	504.18 (page 22): Physician orders should also be required for discharge. They are required for admission and transfers of level, but not discharge.	Change: BMS added language in policy to specify that physician orders are also required at discharge.
7	8/8/2025	504.18 (page 22): Individual sign out/in sheets are reasonable, but it might be burdensome to require them to be in the individual record, at least not until post discharge. Perhaps state that the provider must have them available for review?	No change: At this time, BMS will not be changing sign out/in sheet requirements for inclusion in the individual record.
8	8/8/2025	504.18 (page 19): Case managers in RAS probably need to have job responsibilities defined: examples might be discharge planning, assisting member to address document needs, assisting member to address housing and employment needs, obtaining external appointments upon referral from the physician, coordinating multidisciplinary team meetings, ensuring completion of weekly service reviews, etc.	No change: Please refer to existing BMS policy for the case manager job descriptions; case managers working in residential settings will be expected to meet those case manager responsibilities and standards.
9	8/8/2025	504.18 (Page 22): Weekly treatment summary needs to use the same language/requirements as service plan weekly review. Otherwise reviewers may look for two different weekly documents when only one is required (I assume).	Change: BMS has updated this language to be consistent with language in Chapter 503. This now reads "Service plan weekly review summary".
10	8/8/2025	504.18 (Page 25): If a member is employed in a 3.1 LOC, the employment should be authorized by the team and addressed in the treatment plan with a goal and objectives and reviewed along with the rest of the plan. It also needs to be tracked in the weekly treatment summary (example: member attended his work site four days this week or member was tardy four of five work days this week indicating a need to discuss time management techniques).	Change: BMS agrees with and adopted a modified version of suggested language in policy, focused on determining if the member is therapeutically ready for employment. The treatment team will not be authorizing employment. BMS also specified that a member in a 3.1 level of care may work up to 20 hours a week.

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11	8/8/2025	5018.18 (Page 19): One staff member available on site of an RAS is never sufficient staff regardless of the size of the program. At least two should be the minimum.	Change: A change was made to specify that RAS providers must ensure continuous sufficient supervision, with a minimum of one available staff member on-site at all times.
12	8/8/2025	504.18 RAS (Page 18), could you please mandate review of approved universally accepted MCO UM tool for authorization of admission and continued stay.	Change: An addition was made to policy to indicate that providers must use the universally accepted MCO utilization management tool for authorization of admission and continued stay in residential settings for managed care members.
13	8/8/2025	Page 27 item 3, could you please state “medical and psychiatric” instead of just medical. We have people who are so impaired psychiatrically that they are not benefiting from treatment due to their psychosis but remain in the facility for SUD treatment when they need inpatient psychiatric stabilization.	Change: A change was made to policy, to state “medical and psychiatric”.
14	8/8/2025	Page 31 last exclusion: could you state both group and individual for these activities instead of just group.	Change: BMS updated this language to state group and individual.
15	8/8/2025	Page 33: definition of Human Services degree specifies from an accredited educational program. Many of the individuals working in the field now have on line degrees, for good or ill. Many of those programs are not accredited. Would suggest removal of specification “accredited”. (work force issue).	No change: BMS has decided that accredited will stay in the definition. This aligns with definitions specified in Chapter 503.
16	8/8/2025	504.18 (Page 24): Is the notation that RAS may not include Alcoholics Anonymous or Narcotics anonymous stating that this cannot be a part of the billed services or that the residents are not even allowed to attend these meetings??? I think that if they are not allowed to attend, this could be very detrimental to their recovery and community support systems. The language should be made very clear on this.	<p>Change: A change has been made to policy to specify and clarify that these meetings cannot count toward clinical hours for residential services.</p> <p>RAS providers can hold these meetings, so long as meetings are outside of/do not count toward clinical hours for the designated level of care.</p> <p>However, individuals may attend these kinds of support meetings while receiving treatment. BMS acknowledges these</p>

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			community support meetings can be valuable assets to recovery.
17	8/21/2025	I would like for us to be able to flex our 3.7 beds as 3.5 residential beds- hopefully this will be possible?	Change: A change has been made to policy to indicate that providers are able to flex community 3.7 level of care beds as 3.5 level of care beds in applicable circumstances. Hospital-based 3.7 levels of care cannot flex beds with a 3.5 level of care.
18	9/5/2025	<p>504.18 (Page 24): “RAS may not include:</p> <ul style="list-style-type: none"> • Requirement or pressure to participate in religious services or activities. • Alcoholics Anonymous, Narcotics Anonymous or similar self-help meetings. • Services that do not support individual treatment goals. • Services that are inappropriate due to members’ specific needs and considerations, such as a history of trauma, co-occurring conditions, physical or cognitive limitations, or other individual factors that may limit efficacy of specific treatment or member’s ability to participate in treatment.” <p>My public comment is that under RAS may not include Alcoholics Anonymous, Narcotics Anonymous or similar self-help meetings. If RAS is not allowed to assist members in accessing community self-help, this is detrimental to recovery goals, as the community support is vital to positive treatment outcomes. If not allowed to bill for this service, that is understandable, but to not allow the clients / residents to participate in self-help groups and gain sponsors and work the 12 steps when they choose and need to is a violation of their rights.</p>	<p>Change: A change has been made to policy to specify and clarify that these meetings cannot count toward clinical hours for residential services.</p> <p>RAS providers can hold these meetings, so long as meetings are outside of/do not count toward clinical hours for the designated level of care.</p> <p>However, individuals may attend these kinds of support meetings while receiving treatment. BMS acknowledges these community support meetings can be valuable assets to recovery.</p>
19	9/5/2025	504.18 (Page 24): Also, in CH 504, we are trying to keep family involved for support systems but so many people don't have family, they only have AA and NA as their family. It is unfair to deny people living in these homes to have sponsors and community reinforcement	<p>Change: A change has been made to policy to specify and clarify that these meetings cannot count toward clinical hours for residential services.</p> <p>RAS providers can hold these meetings, so long as meetings are outside of/do not count</p>

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			<p>toward clinical hours for the designated level of care.</p> <p>However, individuals may attend these kinds of support meetings while receiving treatment. BMS acknowledges these community support meetings can be valuable assets to recovery.</p>
20	9/5/2025	<p>504.15.1 Community Peer Recovery Support Specialist Services (Staffing Limitations line item under procedure code) (Page 10) 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? 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..."</p>	<p>No change: A community PRSS follows an individual through their recovery process. There should only be one PRSS working with an individual at a time, out of one agency. A member should not be receiving community PRSS services at more than one agency at a time.</p>
21	9/5/2025	<p>504.15.1 Community Peer Recovery Support Specialist Services (Service Definition) (Page 10) Service Definition section now states that All community "PRSS services are delivered pursuant to the member's person-centered treatment plan...". 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.</p>	<p>No change: Pursuant to Centers for Medicare & Medicaid Services (CMS) guidance, peer support services must be delivered based on an individualized and approved plan of care.</p>
22	9/5/2025	<p>504.15.1 Community Peer Recovery Support Specialist Services (Service Definition) (Page 10) The current Treatment Planning regulations also require sign off and in some instances attendance by a physician or psychologist. Suggestion: Requiring these high level staff signatures, particularly at smaller agencies, may decrease access to the PRSS service.</p>	<p>No change: Pursuant to CMS guidance, peer support services must be delivered based on an individualized and approved plan of care.</p>

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23	9/5/2025	<p>504.15.1 Community Peer Recovery Support Specialist Services (Service Definition) (Page 10 and 11) 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?</p> <p>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.</p>	<p>No change: The list of allowable activities is intended to replace, not supplement, the former list of activities.</p>
24	9/5/2025	<p>504.15.1 Community Peer Recovery Support Specialist Services (Recovery Plan) (Page 14) 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 burdensome and ripe for errors. Currently we do a recovery plan every 90 days which we believe is an effective interval.</p> <p>Suggestion: Keep both the IDT and the recovery plan reviewable every 90 days.</p>	<p>Change: BMS has updated Recovery Plan language to help clarify the intent of this document and expectations regarding review.</p>