Comments for Chapter 503 Licensed Behavioral Health Centers (LBHC)
Effective Date: December 1, 2026

Number	Date Received	Comment	Status Result
1	4/15/2026	I would like to respectfully recommend that the manual be updated to reflect recent statutory changes in West Virginia establishing the Advanced Alcohol and Drug Counselor (AADC) as a licensed profession. In addition to updating terminology from certification to licensure, I encourage the Bureau to ensure that the manual reflects the independent practice authority afforded under statute. Specifically, consideration should be given to aligning AADC with other licensed behavioral health professionals—such as LPCs and LICSWs—where appropriate, including the ability to independently provide and bill for services within their scope of practice. This alignment is particularly important in the context of substance use disorder (SUD) services, including both SUD-only treatment and services provided to individuals with co-occurring substance use and mental health conditions, where appropriate to the provider's training and scope. This clarification will help ensure that AADC are accurately represented as SUD specialists, while continuing to support collaboration with other disciplines when mental health needs extend beyond that scope. Aligning Chapter 503 and certainly 504 when the time comes with current law will promote consistency across Medicaid policy, reduce provider confusion, and support expanded access to substance use disorder services—particularly in underserved areas.	**No change:** No alignment with statute is necessary at this time.
	4/15/2026	**503.32**: Probably needs some clarification/expansion of explanation on the first sentence regarding supervised psychologists to specify the WV BOE of Psychologists and that the supervisees must be approved and listed on the website by that Board. This section should probably also address the Commissioner's desire that all licensed staff and staff with degrees be enrolled and credentialed as rendering providers by 2027.	**Change:** Language has been updated to align with Board requirements.
3	4/15/2026	**503.10**: "Reimbursement is not available for telephone conversations….." may want to clarify that this would not include audio only telehealth contacts.	**Change:** Language has been updated to clarify that telehealth services must conform with the requirements of Chapter 519.17, Telehealth Services.
4	4/15/2026	**503.19.1:** Would really appreciate a statement that this code (H0031 and also 90791) is designed to be a comprehensive global assessment of functioning along with diagnosis, prognosis and treatment recommendations and should not be completed via checklists, multifactor templates, and drop down menus.	**No change:** No further clarification needed.

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5	4/15/2026	**503.14.2:** Same comment as immediately above regarding H0031 and checklists. Also do you want to include permission for LGSW and LCSW to do these assessments?	**No change:** No further clarification needed.
6	4/15/2026	**503.14.3:** NCCI edits do not permit 90791 and 90792 on the same day of service. They should not be billed on the same intake occasion, regardless of date. Both are listed as integrated biopsychosocial assessments therefore they are duplicative except for the medical add on aspect of the 90792. What we see too often are brief medical intakes with reference to the 90791 for the psychosocial aspects. If a 90791 is done as an intake the information is available in the chart. The medical provider then bills the appropriate E/M code for the activity performed (either an OP treatment E/M or a new patient E/M). If no H0031 or 90791 is done then the 90792 would be an appropriate claim for the medical integrated assessment. Also same comments regarding checklists and drop down box intakes.	**Change**: Language has been updated to eliminate potential duplication of services.
7	4/15/2026	**503.15.1:** the psychological testing report should include a summary of background history, reason for referral, presenting problem, summary of the additional information reviewed relative to the member's history or presenting problem including prior treatment history and any associated medications and medical history and the results of any interviews with the member and family.	**Change:** Language updated to align with other assessment/ evaluation sections.
8	4/15/2026	**503.15.1.1:** Individuals eligible to perform psychological testing should be practicing within their identified training, licensure and scope of practice. This may need to be stated here.	**Change:** Language updated to clarify scope of practice requirement.
9	4/15/2026	**503.15.2:** Report should include elements such as summary of background history, reason for referral, presenting problem, summary of the additional information reviewed relative to the member's history or presenting problem including prior treatment history and any associated medications and medical history and the results of any interviews with the member and family	**Change:** Language updated to align with other assessment/ evaluation sections.
10	4/15/2026	**503.16:** should specify that the team that develops the master plan should include representatives of all provider types associated with the plan (responsible for implementation), preferably the actual provider responsible for it, but if not, at minimum a representative member of the appropriate staff type. The need for member participation in this process including review of the plan needs to be emphasized. Too often the member is signing later as a paperwork exercise and does not participate or receive feedback on progress.	**No change:** No further clarification needed.
11	4/15/2026	**503.17.5:** As in the prior manual, this version requires the IS modifier for IOS level of claims. Many payer systems including Gainwell do not accept this modifier and claims are rejected inappropriately. This puts the provider trying to bill correctly to indicate IS level of care in a position that is untenable. Not using the IS modifier makes it impossible for the payer to accurately track IOP activities. Would a single daily rate for IOS be appropriate? Is there a modifier that can be used and widely accepted?	**No change:** No further clarification needed, the IS modifier is used for prior authorization, not claims.

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12	4/15/2026	**503.17.5:** Love the requirement for WVDOE approval for children's IOP however would that letter include a plan for the provision of educational services for the child while enrolled? Recognizing the local politics involved, would it be better to require approval by county Board of Ed? Will you modify the form at 503 G and can you then require such approval from existing programs? Lastly, does the IDT for children/youth in IOP include representation from the school, especially when the school is the referral source? Additionally we have seen children in need of speech therapies and other school based services not receiving them while the child/youth is in IOP (on a few cases, for extended periods of time). Can there be a requirement that the IDT consider the services the school has been providing and make arrangements to continue them as appropriate?	**No change**: Comments are outside the scope of this policy.
13	4/15/2026	**521.11 and 503.14 Assessment Services:** a statement also needs added for both 90791 and 90792. We are frequently seeing providers bill 90791 and 90792 in the same calendar month. Records are typically requested in these situations and upon review, the documentation doesn't support 90792 due to patients just being evaluated for E/M services with no new bio-psychosocial assessment being completed and no change in diagnosis. This is duplicative billing.	**Change**: Language has been updated to eliminate potential duplication of services.
14	4/15/2026	**521.10 Documentation and 503.13 Documentation:** BMS should establish a signature policy. We frequently see documentation signed 14+ days after the service was rendered.	**No change**: Signature requirements are specified in Section 503.14, Assessment Services.
15	4/15/2026	**521.11.3 and 503.14.1 Mental Health Assessment by a Non-Physician:** we are frequently seeing LBHCs bill with the AJ modifier when not allowed for LBHCs. A statement regarding this would be beneficial.	**Change:** Language clarified to note that using AJ modifier is not permitted in this section.
16	4/15/2026	**503.10 OTHER ADMINISTRATIVE REQUIREMENTS***; Services provided via telehealth must align with requirements in Chapter 519.17, Telehealth Services,* BMS should open 519 for comment. We see an issue of providers rendering telehealth without documenting where the patient is or the rendering provider is, which makes it impossible to determine the originating site and distant site, and also to determine if the correct telehealth place of service (02 or 10) was appropriately billed.	**No change:** Comments are outside the scope of this rule. Refer to Chapter 519.17, Telehealth Services.
17	4/27/2026	When will these changes be implemented?	**No change:** No further clarification needed.
18	4/29/2026	**503.21.2 Community Psychiatric Supportive Treatment** Screenshot below it is still referencing the ASAM 3rd edition with this criteria of ASAM Level 2 WM. Chapter 504 was updated to ASAM 4th edition on 3/1/26. For Chapter 503 ABHWV requests, for consistency purposes, that this section be updated to the ASAM 4th edition to follow along with the other SUD services being managed under 4th edition (ASAM 4th usage is effective 6/1/26).	**Change:** Language has been updated to align with latest ASAM guidance.

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19	4/30/2026	**503.3.1 Enrollment Requirements:** Agency Administration: Added the sentence, "It is the responsibility of the provider to ensure that transcripts, diplomas, and certifications are valid." Recommend replacing "ensure" with "make reasonable efforts to ensure".	**No change:** No further clarification needed.
20	4/30/2026	**503.13 Documentation:** Documentation of services that include boilerplate, non-specific, and/or non-individualized language is prohibited. This is different than requiring that a sufficient degree of individualization appear in the note. A prohibition of any and all boilerplate language opens the door for "any" repeating comments to cause all documentation containing it to be disallowed, even if also sufficiently individualized, which isn't likely the spirit. All of the standard language, where used, was developed through auditor requirements.	**No change:** No further clarification needed.
21	4/30/2026	**503.14.1 Mental Health Assessment by Non-Physician:** Available with POS 02 and POS 10 codes. Refer to chapter 591.17 telehealth services. Service limits four per calendar year. When using POS 02 and POS 10 -- Would the "GT" and "95" telehealth modifiers no longer be needed on the claims?	**No change:** No further clarification needed.
22	4/30/2026	**503.14.4 Screening by Licensed Psychologist:** Not new at bottom of page but question noted. Is 96101 an active HCPCS CPT code?	**Change:** Language has been updated to reflect code changes.
23	4/30/2026	**503.17.5 IOS:** Additional information. additional information regarding the language on page 28 stating, "If the IOS program is for children or adolescents, then a approval letter from the West Virginia Department of Education must be attached to the application on submission." Specifically, clarification on the purpose of this change and whether it applies to currently operating Adolescent/Teen IOP programs that do not provide any educational services or interfere with school hours.	**Change:** Language has been updated to clarify that rule applies to both new and existing programs.
24	4/30/2026	**503.18 Intensive Outpatient Services:** Added, “A professional is defined as an individual with a minimum of a master’s degree in a human services field.” Should bachelors be mentioned between HS and Master’s?	**No change:** No further clarification necessary.
25	4/30/2026	**503.19.1 Comprehensive Medication Services:** Mental Health: Question about definition. Could this code definition be expanded to include Spravato (esketamine) administration and monitoring?	**No change:** BMS is not expanding this definition at this time.
26	4/30/2026	**503.22 Assertive Community Treatment (ACT**): They added that the "Weekly intensive summary must include signatures with credentials, date, and start-and stop times." Assuming only the team member completing the document needs to sign. Please confirm.	**Change:** Language updated to clarify documentation requirements.
27	4/30/2026	**503.24.1 Transportation Services:**	**Change**: Language has been updated to clarify

		"This code is only reimbursable for the following programs under this chapter. Intensive outpatient services, community support services, and ACT." Please confirm that CFT falls under community support services and this is not meant to omit CFT.	that this section includes comprehensive community support services.
28	4/30/2026	**503.24.1 Transportation by Minibus:** "This code is only reimbursable for the following programs under this chapter. Intensive outpatient services, community support services, and ACT." Please confirm that CFT falls under community support services and this is not meant to omit CFT.	**Change**: Language has been updated to clarify that this section includes comprehensive community support services.
29	4/30/2026	**503.24.2 Transportation: Per Mile:** "This code is only reimbursable for the following programs under this chapter. Intensive outpatient services, community support services, and ACT." Please confirm that CFT falls under community support services and this is not meant to omit CFT.	**Change**: Language has been updated to clarify that this section includes comprehensive community support services.
30	4/30/2026	**503.26 Service Exclusions:** They added the exclusion, "Services provided (by) a supervised psychologist in a satellite office, which is not the primary site of the practice, and the Board approved supervising psychologist is not available for direct face-to-face supervision." Please confirm that telehealth (real time audio and visual) counts as face to face supervision. The WV Psychology Board permits this as supervision.	**Change:** Language has been updated to align supervision requirements with West Virginia Board of Examiners of Psychologists requirements.
31	4/30/2026	**503.14.3:** Staff Credentials listed are redundant, "must be completed by a physician or a physician, PA, or APRN."	**Change:** Language has been updated to remove repetition and add physician extender.
32	4/30/2026	5**03.1: Other Administrative Requirements.** "reimbursement is not available for a telephone conversation" there are other places in Medicaid manuals that indicates phone calls are billable, feel the language needs to be consistent	**No Change:** Refer to Chapter 519.17, Telehealth Services for BMS requirements on telehealth services.
33	4/30/2026	**503.14.1: Mental Health Assessment by Non-Physician.** "The H0031 should be completed prior to rendering any behavioral health services." Can you please consider a 90791 or 90792 being allowed as an initial service as well? Maybe after a 90791 or 90792 is provided, H0031 needs to be provided before additional services. With this statement, "The H0031 service must not be conducted if it is not intended to provide behavioral health services, i.e. 1915 C Waivers or E&M codes only". Does that mean this scenario is appropriate? An individual unknown to us walks in wanting a medication, the prescriber provides a new patient E&M code, then if the patient decides they want ongoing services, we schedule H0031 as the next appointment.	**Change**: Language has been updated to permit 90791 and 90792 as initial services and to avoid duplication of services.

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34	4/30/2026	**503.17.1: Behavioral Health Counseling, Professional, Individual.** "May be performed by an alcohol and drug counselor (ADC) with a bachelor's degree", I don't feel it is appropriate for someone to provide this service to be provide by someone without a master's degree, adding on an ADC to a bachelor's degree does not provide the some level of education and competency as someone with a master's degree.	**No change:** BMS requires ADCs to have a bachelor's degree in a clinical field.
35	4/30/2026	**503.17.2: Behavioral Health Counseling, Professional, Group**. "May be performed by an alcohol and drug counselor (ADC) with a bachelor's degree", I don't feel it is appropriate for someone to provide this service to be provide by someone without a master's degree, adding on an ADC to a bachelor's degree does not provide the some level of education and competency as someone with a master's degree.	**No change:** BMS requires ADCs to have a bachelor's degree in a clinical field.
36	4/30/2026	**503.16.2: Mental Health Service Plan Development by Licensed Clinician.** "Documentation must contain the licensed or supervised psychologist's, LICSW, or LPC dated, original or electronic signature with credentials…" The proposed language appears to allow for an electronic signature by the licensed provider on the service plan; however, it does not clearly address whether the client (or legal guardian) may also provide an electronic signature, or whether a handwritten ("wet") signature is still required for the client in other sections. With the increased used of telehealth, would electronic signatures be permissable for clients?	**Change**: Language has been updated to permit electronic signature of client on service plan.
37	5/1/2026	**General Comments:** 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 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.	**No change:** Comment is beyond the scope of the rule.

		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. 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.	
38	5/1/2026	**Licensed Clinician Requirements and Restrictions:** 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 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. We also have deep concerns about the prohibitively restrictive requirements in West Virginia requiring a licensed clinician to have to sign off on all documentation in a residential setting. In other states like Pennsylvania, other clinicians can sign off on documentation so long as they are operating under the supervision of a licensed clinician, which we believe is a more reasonable standard. In our Mountaineer facility, for example, which has 100 licensed treatment beds, our licensed clinician must sign-off on approximately 600-700 group notes per week plus approximately 100 individual notes per week as well as approximately 100 ASAM assessments, 100 treatment plans, and 100 level of care assessments ("LOCAs") per week for our residential treatment center in addition to relevant documentation for an additional 130-150 clients per week in our outpatient treatment center. This requirement is especially problematic given overly restrictive requirements to be a licensed clinician in West Virginia, which reduces the pool of available licensed clinicians for providers to be able to hire, which causes staffing challenges and risks providers being unable to offer care because most licensed clinicians are in private practice. In West Virginia, in order to be a licensed clinician, you must be either a licensed professional counselor ("LPC") or a licensed independent social worker ("LISW"), which requires a master's degree. West Virginia does not allow someone	**No change:** Comment is beyond the scope of the rule.

		to be a clinician with a bachelor's level education like other states allow. In fact, a person cannot even be a counselor with only a bachelor's degree—only a case manager or behavioral health technician ("BHT").	
39	5/1/2026	**Behavioral Health Counseling Professional Group & Supportive Group Sizes:** Additional flexibility should be given to providers related to group sizes in "503.17.2 Behavioral Health Counseling, Professional, Group" and "503.17.4 Behavioral Health Counseling, Supportive, Group." Sections 503.17.2 and 503.17.2 should be amended to increase therapeutic group sizes from 12 to up to 16 participants for supportive Group Sizes: 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. West Virginia continues to face workforce shortages, especially with the higher standards of credentialing outlined above. This, coupled with fluctuating census levels, call-offs, and recruitment challenges (particularly in rural communities), presents major challenges to providers. The ability to temporarily expand group sizes up to 16 would help programs maintain full treatment schedules, reduce disruptions in programming, and ensure patients continue receiving clinically indicated services during periods of staffing strain. From a staffing perspective, this flexibility allows providers to deploy limited clinical resources more efficiently without reducing the overall volume of treatment delivered. It can lessen the operational impact of vacancies, turnover, or short-term absences while organizations continue recruitment and retention efforts. This is especially valuable in residential settings where daily structured programming is essential to treatment engagement and recovery progress.	**No Change:** No change in maximum number of members in group therapy.

		Changing group sizes in select circumstances would not reduce quality of care when clinically appropriate groups are chosen and facilitated by qualified staff. Professional and supportive process groups can remain effective with 16 participants when facilitators use structured curricula, strong group management practices, and active engagement strategies. Programs would still retain responsibility to utilize smaller group sizes whenever clinical acuity or patient complexity indicated a more individualized need. Using a 12-to-16 participant allowance only as needed helps providers create a balanced approach that supports both patient care and system sustainability. This supports access to treatment, continuity of programming, improves staffing morale with less strain or stress on rearranging programming, and allows providers to respond to real-world operational demands without compromising individualized clinical decision-making. This flexibility would remain available as a strategic exception, not the expectation or standard practice. 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 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.	
40	5/2/2026	**503.17.1 Behavioral Health Counseling Professional, Individual section:** Under Staff Credentials last sentence indicates "May be performed by an alcohol and drug counselor (ADC) with a bachelor's degree in a clinical field, but only when directly addressing substance use disorder treatment issues". • Comment/clarification: In previous manuals this was included then taken out when the Non-Methadone Medication Assisted Treatment sections were devised. Is it now being added back in that a Bachelor's Level with an ADC can do professional counseling for SUD patients/members that are not on Suboxone, Subutex, Methadone, Sublocade, etc.?	**No change:** BMS requires ADCs to have a bachelor's degree in a clinical field.
41	5/3/2026	**503.17.1 Behavioral Health Counseling, Professional, Individual "Staff Credentials":** Bachelor's degree individuals should not be able to provide professional level counseling regardless of specialized certification/target population (ADC). This training is not equal to and should not be a substitute for a clinical master's degree. These individuals do not have the education/skills to meet the definition of the service. There is also no requirement for the ADC to be directly	**No change:** BMS requires ADCs to have a bachelor's degree in a clinical field.

		supervised by a licensed clinician. This language should be removed/restored to the existing version.	
42	5/3/2026	**503.17.2 Behavioral Health Counseling, Professional, Group "Staff Credentials":** Bachelor's degree individuals should not be able to provide professional level counseling regardless of specialized certification/target population (ADC). This training is not equal to and should not be a substitute for a clinical master's degree. These individuals do not have the education/skills to meet the definition of the service. There is also no requirement for the ADC to be directly supervised by a licensed clinician. This language should be removed/restored to the existing version.	**No change:** BMS requires ADCs to have a bachelor's degree in a clinical field.
43	5/3/2026	**503.19 Non-Methadone Assisted Treatment:** Ch. 519.22 does not appear to replicate this content. Clarify if the service no longer exists for LBHCs and justification for removal.	**No change:** Refer to Chapter 519.22 for rules regarding Medication Assisted Treatment.
44	5/3/2026	**503.22 ACT, 'Member Participation Criteria':** Criteria (a) is now duplicative; the update to Criteria (b) covers both (a) and (b). Consider removing it for clarity.	**Change:** Language has been updated to remove repetition.
45	5/3/2026	**503.22 ACT, 'ACT Team Composition and Staff Qualifications':** Unclear whether removal of 'full-time' language is meant to convey that the ACT core staff can now be full-time equivalent (FTE), part time, etc. Consider adding language to clarify.	**No change:** No further clarification necessary.
46	5/3/2026	**503.22 ACT, 'ACT Team Composition and Staff Qualifications':** Last sentence in #1 "…A registered nurse may serve as a team leader if the team has an additional full time registered nurse" Confirm whether this remaining 'full time' requirement is a typo and will be removed or are two RNs still required on a team if the Team Leader/Supervisor is an RN. If this full time language is removed, consider revising sentence to remove requirement for 2nd RN. If staff are no longer full time, then programs should be able to use one RN for both the Team Leader and RN roles if desired.	**Change:** Staffing language has been clarified.
47	5/3/2026	**503.22 ACT, 'ACT Team Composition and Staff Qualifications':** Staffing requirements should be dependent on the number of ACT members served by the core team. The current full time staffing requirement for ACT teams is a barrier when starting a new team/serving fewer members. However, removing all 'full time' language outright will jeopardize the fidelity of ACT. By eliminating this language, a provider could staff its core team utilizing only FTE staffing regardless of members served by the team, e.g., a 120-member team could be staffed by 48, .25 FTE core staff members or with all part-time staff. Consider adding language linking a full time requirement to the 1:10 staffing ratio requirement in this section. Teams with 50 or more members should still be required to designate a full time core team who do not work outside of the ACT program to maintain fidelity of the program/services.	**No change:** No further clarification necessary.

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48	5/3/2026	**503.22 ACT, 'Caseload Mix and Ratios':** Removed Sentence: "With the exception of the team physician, PA, or APRN, none of the ACT Team can serve non-ACT members." Consider adding the removed sentence back with a revision that this only applies to teams with 50 or more members.	**No change:** No further clarification necessary.
49	5/3/2026	**503.22 ACT, 'ACT Fidelity Indicators':** Consider adding language to clarity how 'Each team has one registered nurse in a program of 50 clients' is impacted with the removal of full time language. Currently, providers are required to add an RN for every 50 clients up to 120 clients. If there is no longer a full time requirement for the RN, it is unclear if additional RN's are needed.	**Change**: Language has been updated to clarify equivalent FTEs are required to staff larger programs.
50	5/3/2026	**503.22 ACT, 'Documentation':** Last sentences of (2) "The document must show that the team did weekly intensive reviews. Weekly intensive summary must include signatures with credentials…." As is, the wording of the final sentence would require the team to sign every member's summary each week. Ascentra provided TA for this process to eliminate signing potentially 120 weekly summaries as a team. Instead, the team signs, dates, etc. the daily log stating all weekly summaries were reviewed. Consider revising the last sentence to clarify whether all staff must sign, date, etc. each member's weekly summary document vs. have documentation that the summaries were reviewed and it is signed, dated, etc. by the team.	**Change:** Language has been updated to clarify documentation requirements.
51	5/3/2026	**503.22 ACT, 'ACT Team Certification Process':** Regarding deleted recertification content, confirm the recertification process ends with these updates. Once a provider applies and is approved to have an ACT team, there is no subsequent renewal/recertification process.	**No change:** No further clarification needed.
52	5/3/2026	**503.22 ACT, 'ACT Team Certification Process':** Confirm staff changes are no longer required for submission to BMS. The new process is to have documentation on site regarding personnel changes only.	**No change:** No further clarification needed.
53	5/3/2026	**503.22 ACT, 'ACT Team Certification Process':** Confirm if completion of the ACT Team Modification form is the appropriate documentation to have on file or is the roster and personnel files for the current team sufficient.	**Change:** Language updated to require both ACT Team Modification form and roster/personnel files should be retained for documentation.
54	5/3/2026	**503.22 ACT, 'ACT Team Certification Process':** If staffing vacancies are no longer reported to BMS, what is to stop a provider from maintaining vacancies for an extended period? Running a whole team with one staff person, no doctor, etc. for months? Consider adding language about reporting to BMS when a position has been vacant more than 60/90 days to ensure program fidelity.	**No change:** Provider must continue to document compliance with staffing requirements.
55	5/3/2026	**503.22, ACT MISC:** Consider renaming the application/modification document to 'Application for Assertive Community Treatment (ACT) Team AND Modification form'	**No change:** No further clarification needed.

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56	5/4/2026	Crisis Stabilization refers to levels that is in the 3rd edition of ASAM and this needs to be upgraded to the ASAM 4th edition.	**Change:** Language has been updated to refer to the latest approved standards of the American Society of Medicine (ASAM) guidance.
57	5/4/2026	**503.17.5.** It needs to be specified we are using the most current edition of ASAM (ASAM 4th edition). MCO would like to standardize their PA to include the dimensional assessment for all SU and co-occurring for IOP.	**Change:** Language has been updated to refer to the latest approved standards of the American Society of Medicine (ASAM) guidance.
58	5/4/2026	Finally IOP should have recertification every two years.	**Change:** Language has been updated to reflect that Intensive Outpatient Programs are required to be recertified every two years.
59	5/4/2026	**Background:** Need a space between facility based	**Change:** BMS has removed typographical errors from the document.
60	5/4/2026	**503.3.1 Enrollment Requirements: Agency Administration:** Annual credentialing committee	**No change:** No further clarification needed.
61	5/4/2026	**503.3.1 Enrollment Requirements: Agency Administration:** Or you might want to put the annual requirement here?	**Change:** Language has been updated to clarify that documentation of an annual credentials review must be filed in each staff person's personnel file and available for review.
62	5/4/2026	**503.6 Service Certification Requirements:** This doesn't match the 90 day review requirement. It reads as if they can choose to not review for 180 days?	**Change:** Language has been updated to clarify review requirements.
63	5/4/2026	**503.10 Other Administration Requirements:** This seems to not match the telehealth requirements in 519 which includes "landline and wireless communications."	**Change:** Language has been updated to clarify that any service provision using telehealth or any electronic technology in lieu of a face-to-face

			encounter must align with the requirements of Chapter 519.17, Telehealth Services.
64	5/4/2026	**503.11 Focused and Coordinated Care Services:** Now that PRSS requires a Service Plan will it be considered a Coordinated Service? If so, we might want to add it here.	**No change:** No further clarification needed.
65	5/4/2026	**503.14.1 Mental Health Assessment by Non-Physician:** Typo remove "="	**Change:** BMS has removed typographical errors from the document.
66	5/4/2026	**503.14.1 Mental Health Assessment by Non-Physician:** Make this match the 90791 and 90792 to say , "for which the member must be present.	**Change:** Language was updated to align with other sections of policy.
67	5/4/2026	**503.14.1 Mental Health Assessment by Non-Physician:** We suggest adding efficacy of medications along with the compliance which would match our scoring tool	**Change:** Language was updated to align with other sections of policy.
68	5/4/2026	**503.14.2 Psychiatric Diagnostic Evaluation (No Medical Services):** We would suggest adding start/stop times even though it's an event code-- this helps look for overlapping times.	**Change:** Language was updated to add documentation requirements.
69	5/4/2026	**503.14.2 Psychiatric Diagnostic Evaluation (No Medical Services):** We suggest making this consistent with the H0031 purpose which says " Medically Necessary Purpose Statement (i.e., indicates a known or suspected behavioral health condition requiring an assessment to determine diagnosis(es) and treatment recommendations.)"	**Change:** Language was updated to align with other sections of policy.
70	5/4/2026	**503.14.2 Psychiatric Diagnostic Evaluation (No Medical Services):** Might want to change this to "Approved Licensed Clinician" or add LPC and LICSW	**Change:** Language was updated to include Licensed Professional Counselor (LPC) and Licensed Independent Clinical Social Worker (LICSW).
71	5/4/2026	**503.14.2 Psychiatric Diagnostic Evaluation (No Medical Services):** Adding intensity would better match our scoring tool … "including intensity, duration and frequency of symptoms"	**Change:** Language was updated to clarify documentation requirements.
72	5/4/2026	**503.14.3 Psychiatric Diagnostic Evaluation (Includes Prescribing of Medications):** We suggest adding start/stop times here as well	**Change:** Language was updated to add

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			documentation requirements.
73	5/4/2026	**503.14.3 Psychiatric Diagnostic Evaluation (Includes Prescribing of Medications):** Same purpose for H0031 and recommended for 90791 "Medically Necessary Purpose Statement (i.e., indicates a known or suspected behavioral health condition requiring an assessment to determine diagnosis(es) and treatment recommendations.)"	**Change:** Language was updated to align with other sections of policy.
74	5/4/2026	**503.14.3 Psychiatric Diagnostic Evaluation (Includes Prescribing of Medications):** Change to "including intensity, duration and frequency of symptoms" to better match our scoring tools	**Change:** Language was updated to clarify documentation requirements.
75	5/4/2026	**503.14.4 Screening by Licensed Psychologist:** Typo remove "="	**Change:** BMS has removed typographical errors from the document.
76	5/4/2026	**503.14.4 Screening by Licensed Psychologist:** Need to replace 96101 to either Psychological Testing or add the codes 96130/96136	**Change:** Language was changed to update codes.
77	5/4/2026	**503.15.1 Psychological Testing Evaluation Services by Professional:** Typo- need a space between computer administered	**Change:** BMS has removed typographical errors from the document.
78	5/4/2026	**503.15.1.1 Psychological or Neuropsychological Test Administration & Scoring: First 30 minutes:** Typo- need either a space or hyphen	**Change:** BMS has removed typographical errors from the document.
79	5/4/2026	**503.15.1.1 Psychological or Neuropsychological Test Administration & Scoring: First 30 minutes:** Might want to change this credentialing to match above language: "Must be performed by a West Virginia licensed psychologist in good standing with the West Virginia Board of Examiners of Psychologists or a supervised psychologist who is supervised by a Board Approved Supervisor.	**Change:** Language has been updated to align with other sections of policy.
80	5/4/2026	**503.16 Service Planning Requirements:** Is this always physician or should it also be an approved licensed clinician (i.e., psychologist, LPC, LICSW)?	**Change**: Language has been updated to include licensed clinicians.
81	5/4/2026	**503.16.1 Mental Health Service Plan Development:** Should it indicate here that services provided under the Clinic NPI must include a physician/extender in Service Planning?	**Change**: Language has been updated to clarify that services provided per this section under Clinic NPI must include a physician/physician extender.

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82	5/4/2026	**503.16.1 Mental Health Service Plan Development:** Typo- remove hyphen and add a space	**Change:** BMS has removed typographical errors from the document.
83	5/4/2026	**503.17.1 Behavioral Health Counseling, Professional, Individual:** This would only be true for coordinated care so should it say "the intervention must be reflective of the goal and/or objective on the Service Plan (Coordinated Care) or Treatment Strategy (Focused Care)? Or you can use the language for Professional Group below, "If there is a Service Plan…"	**Change:** Language has been updated to align individual and group policy.
84	5/4/2026	**503.17.1 Behavioral Health Counseling, Professional, Individual:** We suggest adding another bullet for "Service Code and/or Descriptor"	**Change:** Language was updated to add documentation requirement.
85	5/4/2026	**503.17.1 Behavioral Health Counseling, Professional, Individual:** In the previous manual "Plan for continued therapy" is a separate bullet. This reads as if they can have either a response or a plan-- they were previously two different requirements	**Change:** Language has been clarified to retain plan for continued therapy.
86	5/4/2026	**503.17.2 Behavioral Health Counseling, Professional, Group:** We suggest adding a bullet for code and descriptor	**Change:** Language was updated to add documentation requirement.
87	5/4/2026	**503.17.5 Intensive Outpatient Services:** Typo- "an"	**Change:** BMS has removed typographical errors from the document.
88	5/4/2026	**503.17.5 Intensive Outpatient Services:** We would suggest adding that changes to the program related to eligibility criteria and/or clinical hours must be approved by BMS.	**No change:** No further clarification needed.
89	5/4/2026	**503.20 Comprehensive Programs of Services:** Should there be a reference to having to be tied to the behavioral health condition rather than cognitive impairment?	**No change:** No further clarification needed.
90	5/4/2026	**503.20.2 Comprehensive Community Support Services:** Is this right? We see CFT with therapy occasionally? Or does concurrently mean overlapping times but they can get services outside of CFT but not during the CFT program timeframe?	**No change:** No further clarification needed.
91	5/4/2026	**503.20.2 Comprehensive Community Support Services:** Typo	**Change:** BMS has removed typographical errors from the document.
92	5/4/2026	**503.20.2 Comprehensive Community Support Services:** Typo	**Change:** BMS has removed typographical errors from the document.
93	5/4/2026	**503.21.2 Community Psychiatric Supportive Treatment:** Typo? Something appears cut off here	**Change:** BMS has removed typographical errors from the document.

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94	5/4/2026	**503.22 Assertive Community Treatment:** Is this a typo or a change? Previously Five or more for the combined hospital/Crisis Stab in 24 months	**No change:** No further clarification needed.
95	5/4/2026	**503.22 Assertive Community Treatment:** "full time" was removed? Does this mean they no longer have to be full time to the ACT team?	**No change:** No further clarification needed.
96	5/4/2026	**503.22 Assertive Community Treatment:** Same as above, no longer full time?	**No change:** No further clarification needed.
97	5/4/2026	**503.22 Assertive Community Treatment:** "With the exception of the team physician, PA, or APRN, none of the ACT Team can serve non-ACT members." statement from the old manual has been removed. Does this mean none of the staff have to be full time? If so, are there any minimum requirements as to what percent they need to work with ACT? May more than person serve as a representative of the core ACT team… meaning can you have multiple part-time therapists serving as the two required therapists?	**No change:** No further clarification needed.
98	5/4/2026	**503.22 Assertive Community Treatment:** We suggest adding "who is responsible for addressing" to match our scoring tools	**Change:** Language has been updated to add documentation requirement.
99	5/4/2026	**503.22 Assertive Community Treatment:** What happens if they don't replace within 30 days? This might be more of a retrospective review question but wondering if there should be something that states that failure to have a replacement may result in disallowance or something like that?	**No change:** No further clarification needed.
100	5/4/2026	**503.23.4 Positive Behavioral Support Services - Implementation:** Typo	**Change:** BMS has removed typographical errors from the document.
101	5/4/2026	**503.26 Service Exclusions:** Might also want to add AA/NA or Twelve Step Support Groups	**Change:** Language has been updated to include additional exclusions.
102	5/4/2026	**503.26 Service Exclusions:** Typo: services provided "by" a supervised psychologist...	**Change:** BMS has removed typographical errors from the document.
103	5/4/2026	**503.29 Documentation and Record Retention Requirements:** Typo	**Change:** BMS has removed typographical errors from the document.
104	5/4/2026	**503.29 Documentation and Record Retention Requirements:** It's covered elsewhere but might want to add code and descriptor here as well	**Change:** Language has been updated to add documentation requirement.