1. The focus of our work is child/adolescent. It is common for us to also work with parents in how to manage/influence the child's behavior. We often help them learn to manage ADHD or ODD symptoms, and assist them in developing behavior charts and then monitor follow-through to help deal with behaviors. Do we bill this as family therapy or community support?

   Answer: The client is the focus of services provided to the parents, i.e., how to manage/influence the child's behavior. Both family therapy and community support may be provided to parents. Billing depends on the intervention with them. Community support focuses on skill building and the development of natural supports while therapy focuses on therapeutic interventions. Be prepared to defend the service that is billed. In recent post-payment reviews, the primary reason for disallowing a claim is that the case note indicates "family therapy was provided," but the service was billed as community support. Be consistent between the case note and billing.

2. If a client who is open to our agency goes for a short time to a medical nursing facility for physical therapy and rehabilitation of an injury, can the case manager continue to provide services to the client while they reside in the nursing facility? The possible services would include Community Support Individual to help them develop the skills needed to reduce the functional impairments of their mental illness that will help them to live more independently in the community. I would assume that providing Case Management Transition Linkage and Aftercare would be appropriate if helping the person transition from the nursing facility to their own home/apartment or into a possible group home placement, and possibly Case Management Mental Health in order to facilitate changing the payee of the consumer prior to release from the nursing home.

   Answer: If the individual is Medicaid eligible, services may continue while s/he is in the nursing home as long as the services continue to be medically necessary and do not duplicate services provided by the nursing home.

3. We are looking into doing some groups this winter and billing them under Medicaid as Community Support Group. The groups will meet at locations other than our office, like a church or school. The clients will have Mental Health Assessments and Treatment Plans active at the time of service. The first group would include parents and children. It would be a multi-family group. The goal would be to teach parents and children anger management skills. The second group would have the children involved in the Mental Health Assessment and Treatment Plan, but the group itself would be teaching parents Behavioral Parent Training. It would be a group of parents meeting to learn specific behavior management skills to use with their children. Do the descriptions of these groups meet the criteria for Community Support Group? We are historically a children's provider; we assume it is okay to bill for parents as well. Do we have to have "Community Support Group" on our BALC certificate?

   Answer: 1) DMH will reimburse providers for CSG if all requirements of Rule 132 are met, including: a) The CSG intervention directly addresses a need identified on the MHA and covered in the ITP b) The identified need is directly the result of a mental illness. So, assuming the consumer is the child, the services would be billed to the child's name and provided to remediate symptoms of the child's mental illness. They would need to very clearly show that the child's illness/symptoms can be expected to be reduced by the parent improving specific skills focused on in the group, i.e., medical necessity. 2) Providers must have each service they provide listed on their certificate. Although you did not directly ask this question, we thought it was important to note that the idea of providing community support in the community is to reinforce the utilization of natural supports. Just using space of another entity does not reinforce that concept. This may be billing off-site rates for something they could just as easily be done within your own on-site space. There should be a reason (besides the requirement that 60% of CS be provided off-site) for using another space.

4. How do we bill contact with a family member (parent) over the phone, discussing how a child is doing on their treatment plan goals (using a behavior chart, level of depression, etc.) Should we

bill it as CS-I because it is support and consultation to the support system that is directed primarily to the well being and benefit of the child?

Answer: Yes, this sounds like CSI.

5. Following are examples of notes I received from a case manager. The second is a revision that occurred when I said that I did not see a service defined in the note. Only the body of the notes are included. They were billed as 0.5 hr of case management and read: "To see that client has his medications for one week, I took client to pharmacy to get his medications. Client did not speak much as usual. He claims to be taking his medications on a daily basis with his mother's prompting." The revision read: "Client is in need of support to pharmacy to receive his medications to ensure compliance and to ensure medication refills as he would not do so independently. Client has a history of noncompliance with getting medications." Is there a billable service provided when a client who, without a ride, would not get his meds, go to the MD, get labs etc, and the ITP addresses this need with a statement such as "Problem: client states trouble getting medications?"

   Answer: You're on the right track in asking what service was delivered. Transportation is not a billable service. If a service was delivered while driving, and is described in the note, it would be billable. There is no service in either of the notes submitted. An example of providing community support individual might be: "With client on the way to getting meds, reviewed with him how to order meds himself, showed him the location where he could pick up public transportation, discussed with him how he would be sure to be able to pay for the bus, and asked him to repeat the information back to me."

6. We would like to bring to the committee's attention that when delivering "off-site community support group" a staff member must have at least 4 consumers in the group for the provider to capture a billing amount similar to "off-site community support individual." From the perspective of providing individualized services, minimizing time spent writing billing notes, QA of billing notes, data entry of billing, and capturing billing revenue we find it is best for the consumer, the staff, and the agency to provide these services to consumers individually rather than as a group because of the current rates.

   Answer: Services are to be provided in response to the consumer's needs and desires, not according to billing concerns of the provider.

7. Will the application of the 60% threshold for CS services to be delivered in the community be applied to CSG and CSI in aggregate or separately? It is more difficult to provide CSG in community settings, but if taken together with CSI, the threshold is much easier to attain.

   Answer: It will be applied separately to CSI and to CSG.

8. A counselor/clinician (MHP, QMHP) can bill for community support if they are sitting in with a client at a psychiatric appointment to assist them in discussing medication concerns with the doctor, or to help the client explain symptoms, and difficulties they are having on a particular medication as long as they are not billing for transportation time or time waiting in the lobby for the doctor. This can be billed whether it is an outside psychiatrist the client is seeing or whether it is our own psychiatrist at Gateway. Is this correct?

   Answer: This is acceptable.

9. Please review the following goal that we would like to use in our residential homes. Will it be acceptable as both Case Management & Community Support & can both services be listed in the method or do we have to have separate goals? PROBLEM STMT: Client lacks ability to access & utilize community resources independently. LONG TERM GOAL: Client will identify & utilize community resources to maintain entitlements/benefits, MH & community services INTERMEDIATE OBJ: Client will receive services/participate in activities for assessing/identifying current needs to coordinate, link to & maintain access to MH & community services for continuity

of care including; transitioning into placements & communities; client-specific advocacy & support for problem solving & linkage w basic resources (applying for cash, medical, & other public entitlements; locating housing; obtaining medical & dental care); coordinate social, educational, vocational, & recreational services to assist in building community/family support. METHOD: CM-MH/CCC; as indicated by service performed) or CS. MEASURE: After exploring & evaluating options to meet needs client will obtain/maintain benefits & entitlements. START: 6-28-06. REVIEW: 12-28-07

Answer: This objective is more like a service definition, not a recovery oriented objective that is client-directed, client specific, that reflects the client's preferences. It appears that you may be trying to develop a template in order to simplify client notes, but the objectives must focus on the specific needs of the individual. The objective, with some additional detail, may be acceptable for case management activities. However, it is not acceptable for community support. The objectives must be specific so it is obvious to the client when he/she has achieved an objective.

10. What if your site is not certified? We have several program 830 clients who lease their own apartments in a building that we do not own but which are supervised 24/7.

    Answer: Community Support services provided by residential staff to clients in supervised residential program must be billed as CS-Residential. We recommend that you work with your Region staff to either change the program to supported residential or have the site certified for supervised residential.

11. We are planning a community integration group called "Getting to Know Your Community," the purpose of which is to help people identify and get safely to local resources, to learn the practice of street smarts etc. A group will start in front of our building, walk to local resources (post office, library, etc.) and work on building community integration knowledge and skills as they proceed. Since this takes place in a natural, community setting and the purpose is to enhance the ability to live in the community by practicing skills in the community, would we consider it off-site?

    Answer: Yes, we would consider this off-site.

12. Are Community Support services limited to a certain number of hours per year per consumer?

    Answer: No.

13. How do we bill for consulting with the family to monitor a child's behaviors when the child is not there - as family therapy, case management, or not at all?

    Answer: Community Support-Individual is the most appropriate service to bill for consulting with the family.

14. Specialists often sit in with the older consumer when they visit the psychiatrist. Their function is not just to sit and listen, but to supplement information that the consumer provides to the psychiatrist, correct misinformation, remind them to tell certain things, and coach them through the session with the psychiatrist. How should this be billed?

    Answer: If staff is "doing with" and coaching the consumer, it would be community support-individual. If staff is "doing for" the consumer, it would be case management-mental health. The description sounds more like community support-individual.

15. A PSR program is located across the street from the community college. CS-G Clients are walked over to the college for a computer skills class. They have been billing this as on-site because they can walk to the site. Should this be billed as off-site?

    Answer: Billed services must be provided by provider staff. Walking the consumer(s) someplace is not a billable service. If community college staff provides the class, it is not billable.

16. We have several CS-Group clients who, due to their mental illness, have no support system except our staff and very limited access to transportation. If we took them to eat and bowling, to decrease their isolation and increase peer interaction, could you give us an example of how to write the note to ensure it is a billable activity?

    Answer: Going bowling and to dinner may or may not be a billable activity. Things that are billable are provision of a service intervention specific to the individual's needs as specified in the treatment plan. When documenting the provision of the service, document the active intervention that took place, how it related to the ITP and the individual's response to the treatment.

17. We just started a new group that meets several blocks from our clinic in a hospital computer-training lab with a bank of 10-12 computers and an overhead. The building is not a Medicaid certified site but is used for general training. It is not associated with psych activities. The group is led by a licensed occupational therapist (OT) who works with clients to help their concentration, impulse control, socialization, ability to handle frustration and interpersonal skills. Using a computer lab outside of our clinic has a normalizing benefit and puts clients in the community. Most people have had some computer training in the past and they have typically left frustrated and feeling bad about themselves. The OT is trying to change that; she is not a computer expert. Her strength is providing treatment to clients and she is using computers as another way of engagement and care. Does this qualify as off-site?

    Answer: The service as described is billable as CS-Group, off-site.

18. Are we able to bill for CS-Individual and Group, off-site, for services provided to clients in a nursing home?

    Answer: Yes, the services are considered to be off-site.

19. In regard to youth, the rule states that points will be deducted if taken out of their natural supports, such as school. If they were seen during study hall, would this be considered a deduction? Most kids have limited time they can be seen with homework, dinner, and early bedtime during the school year.

    Answer: The corresponding Rule language states: "CSI services shall occur during times and at locations that reasonably accommodate the client's needs for services in community locations and other natural settings, and at hours that do not interfere with the client's work, educational and other community activities."132.150 e)3)C) The focus is the client and his/her needs.

20. Client lives in a group home at Agency A. Agency A provides CS-Residential, Individual, Group. Client attends Agency B for PSR services. Skills learned at PSR are practiced and implemented via CS-Group, Individual services provided by Agency B as they take clients into the community. During the transport home they also discuss ways to practice and implement skills learned at PSR etc. The services provided by Agency B do not include case management nor do they duplicate services provided at Agency A. Can two agencies work with a member and both provide CS services?

    Answer: Two agencies may serve one individual. Both agencies must be fully compliant with Rule 132 by having completed assessments and ITPs. Neither may bill for the same service provided at the same time. Each may bill only for services provided by their own staff.

21. We have an out of home placement program with foster parents. They are considered contract employees. When staff are discussing the kids in placement with the foster parents how should we consider the foster parents? Are they "other professionals" and so these conversations would be Case Management-Client Centered Consultation? Or are they "family" and so these conversations would be considered Community Support-Individual?

    Answer: Foster parents are considered to be family. Support and consultation to the client's

support system, directed primarily to the well-being and benefit of the client is Community Support-Individual.

22. How does strengths-based case management fit into the new services structure?

    Answer: Case management is primarily focused on 'getting for' the consumer while community support is primarily focused on 'teaching how' and building capacity and capabilities within the consumer. To the extent 'strengths based case management' is 'doing for' a consumer it may be billable as case management while interventions that are 'teaching how' and building capacity within the consumer should be billed as community support.

23. Must progress notes be signed by the professional supervising a paraprofessional?

    Answer: No.

24. What credentials & certifications are required of a CS worker and a CS supervisor?

    Answer: The Rule does not separately define the credentials of a CS Supervisor. A staff member with any of the following credentials can bill CS: RSA, MHP, QMHP, LPHA.

25. If you take consumers bowling, can you bill CS?

    Answer: Taking consumers on a recreational outing is not automatically billable as community support individual or group. Each consumer for whom billing is submitted must have an assessed need that relates to the outing, have a defined goal/objective on their individualized treatment plan that relates to the assessed need, and should only be billed for the amount of time involving an 'active intervention' between the billing staff and the consumer. If a given consumer does not meet these criteria, they may go on the outing but the agency should not submit billing for them.

26. Define what you mean by "trauma management". Is it past trauma, current trauma and does it include crisis?

    Answer: The reference to trauma management in the CS definition is focused on teaching the consumer how to manage and cope with their ongoing reaction to their particular history or trauma. It is trauma in general, both past and present. Crisis services should be provided under crisis intervention, not CS.

27. Can a Rehabilitative Services Associate (RSA) provide CS?

    Answer: Yes.

28. Do ALS children/adolescents in traditional mental health counseling also need to have CS?

    Answer: No. However, CS has been shown to be an effective companion to office based counseling by providing a field based support to help the child and family practice plans, issues, and interventions discussed in session.

29. How does intensive CS differ from SASS?

    Answer: CS is a service which may be billed under SASS.

30. A consumer-run snack shop is in our agency building - is contact at that location considered to be office or natural setting?

    Answer: If it is located on a DHS/DMH certified site, the service would be considered office based.

31. 60% of CS services must be in the natural setting. How do you classify telephone contacts with consumers at their home?

Answer: All phone contacts are on-site services and therefore not considered to be in a natural setting.

32. How do the medication-only consumers fit into the 60% offsite services for CS?

    Answer: The requirement for 60% in natural setting applies only to the provision of community support, individual, group and team services. There is no similar restriction on medication services.

33. How is the 60% offsite calculated for offsite services?

    Answer: The 60% will be applied across the agency by individual service (CSI, CSG, CST), not by individual consumer.

34. Can we provide individual support in the library or in other places, not necessarily in the consumer's home?

    Answer: Yes. Natural settings are places that the consumer frequents, not just their home.

35. Can the same staff provide Case Management and CS-Individual or Group?

    Answer: Yes.

36. What is the primary difference between Case Management Services and CS Services?

    Answer: Case management is narrowly defined as assisting the consumer to access needed resources and supports. CS services are active interventions that are teaching consumers 'how' to access needed resources, supports, and skills and supports them through the application of these capacities.

37. If we are not sure of where a service would fall (CM-MH, CM-TLA, or CS) is it better to err on the side of CM or CS, so as to minimize the risk of services being disallowed in a post-payment review?

    Answer: You should seek clarification. To default to any one service definition is an audit risk.

38. WRAP wasn't mentioned in the PSR presentation, but was stressed in CS. We currently bill WRAP as skills training because it has a curriculum. Is this how we should continue to bill individual & group WRAP sessions? If not, how should we bill WRAP come July?

    Answer: If WRAP is provided as part of PSR, it should be billed as PSR service. If it is delivered in a group that is not part of PSR, it should be billed as CS-Group.

39. Child and adolescent advocacy, wrap around services for children and a transition plan for adolescents - are these CS Services?

    Answer: It depends on the activities. If you are referring an individual to other services, it is more likely to be case management. CS involves more active participation in the provision of the services by the staff.

40. If we practice socialization skills on site, is that CS Group?

    Answer: It depends. If it is a structured group that is part of PSR, it may be billed as PSR. If it is a structured group for consumers that are not part of PSR, it would more likely be CS-Group. In any case, only time of direct staff intervention/interaction would be billable.

41. Do you have to provide all types of CS or can you provide just CS-Individual and CS-Group?

Answer: There is no requirement that an agency has to provide all types of CS. Agencies should provide the services needed by the clients they serve.

42. How are you defining "in the community, in natural settings"?

    Answer: It is out of the provider's office setting, provided in the community which may include the person's home, school, local establishments or businesses as examples.

43. What is CS on-site, as opposed to CS off-site? What are the services?

    Answer: On-site and off-site refer to the place of service and not to the nature of the service. Please see service definition for allowable activities. See rule for definitions of on-site and off-site.

44. Should off-site drop-in centers be billed as CS?

    Answer: No. Only activities that meet the service definition of CS, are reflected as needs on the consumers current assessment, are reflected on the consumers treatment plan, and appropriately documented in a progress note should be billed to CS. If there are activities within the drop-in center that meet these criteria, those discrete activities may be billed as CS.

45. Are any taxonomy services excluded by a person receiving CS?

    Answer: CS-Individual and Group may be billed with any Rule 132 service EXCEPT for ACT and CS-Team.

46. What groups do you recommend for CS to bring services outside of the agency; other than shopping for groceries, what do you suggest?

    Answer: CS services should be the application and integration of skills learned. Group focus should be consistent with the needs of the consumer's in the group. Examples might include learning how to access community resources (recreation, benefits, transportation, etc), practice of social skills, etc.

47. Please define "in the community" & "natural setting" as used in CS.

    Answer: In the community or natural setting is meant to include locations within the community that are not certified by DHS/DMH. Most supported residential programs will be considered as natural settings.

48. Will DMH documentations be revised for CS?

    Answer: Documentation requirements can be found in Rule 132, Section 132.100.

49. What is the staff/consumer ratio in CS-Group?
    Answer: Not to exceed 1 staff for every 15 consumers in a group.

50. When can you bill for two persons to lead CS-Group?
    Answer: Two staff shall not bill for the same consumer for the same time period for the same service.

51. If not in the office, where do you envision CS-Group to be held?
    Answer: In the community or other natural setting.

52. How does medical necessity interface with CS in providing treatment supports for areas such as vocational or educational needs?
    Answer: If the need is indicated in the consumer's current assessment, pre-vocational and pre-educational supports may be provided and billed under CS. If the assessment does not indicate these needs, the service would not be medically necessary and could not be billed.

53. Can a Residential Support Aide (RSA) bill CS-Group services while working in a supervised residential site?
    Answer: (DMH assumes the questioner meant "Rehabilitative Services Associate".) RSA may bill CS-Group at the appropriate rate. However, services provided within a supervised residential site should be billed as CS-Residential (group mode) and only activities delivered in the community (e.g., not within the facility) should be billed as CS-Group or CS-Individual.

54. How are vocational non-Medicaid services counted in our expected percentages?
    Answer: Vocational non-Medicaid services do not count toward the 60% in the community requirement for CS.

55. "Ten Best Practices for CS", talks about caseload size being "small enough". What concrete numbers or ratios were used to define a "small" caseload? What are the minimum, optimal, and maximum caseload sizes for a CS worker? Do the numbers include a defined mixture of acuity?
    Answer: DHS/DMH is not setting minimum or maximum case load sizes for CS. Case loads should be of appropriate size to ensure that staff provide the prescribed level of services as reflected on the treatment plans of the consumers for whom they are responsible. Case load size should therefore factor in consumer acuity mix within a given staff members responsibilities.

56. What is the interface, if one exists, between SASS & C&A - CS services; is CS less intensive than SASS; can youth in SASS also receive CS; who pays for CS while a youth is SASS eligible?
    Answer: CS is a Rule 132 service that may be billed as part of SASS through HFS during the 90 day SASS period.

57. How does the LOCUS fit in with CS & consumer/family choice in level of care?
    Answer: The LOCUS is to be used as a clinical tool to assist the clinician in determining appropriate level of care.

58. Is it accurate to say you can bill CS-Individual & CS-Group with family members/supports without the consumer present? Can you provide an example?
    Answer: It is possible. The intervention must be for the primary benefit of the enrolled consumer, related to a need on the enrolled consumer's current assessment, and reflect a goal on the consumer's treatment plan.

59. Can an individual receiving CS Services also receive CM services?
    Answer: Yes.

60. Do we bill skill building trips into the community (for consumers practicing skills taught to them by PSR staff) as CS-Individual or CS-Group?
    Answer: It depends on whether this is done in a group or with an individual.

61. If you use RSA level staff to provide CS services, who will complete the treatment plans and MH assessments?
    Answer: RSA staff may provide CS services but are not qualified to do treatment plans or assessments. Please see those service definitions in Rule 132 (Section 132.148) for the credentials for these two services.

62. When consumers living in a 24-hr supervised group home are taken on an activity in the community, is it considered CS-Group as opposed to CS-Residential?
    Answer: CS-Group. Only services delivered within the certified 24 Hr supervised facility should be billed as CS-Residential. And, only the provision of an active intervention is billable.

63. Is the expectation that a consumer will be receive CS in a natural setting rather than office-based counseling the first & primary direction of service?
    Answer: Rule 132 requires that at least 60% of CS be provided in a natural setting and out of office.

64. What do we do if consumers request office-based skills groups, but the agency is limited by the required service mix?
    Answer: An agency can offer both office and community based services. Up to 40% of CS services may be provided in an office setting.

65. For consumers receiving CS-Individual, CS-Group & PSR services, may we also bill other Medicaid MH services such as the various case management services, individual/group therapy & counseling, if we are certified to provide them?
Answer: Yes, if the services are medically necessary and included on the ITP.

66. How does "explore trauma management skills" in CS differ from work in individual therapy?
Answer: CS goals addressing trauma management skills would typically be complementary to individual therapy. Most often, CS interventions would be concrete, skill development such as learning breathing exercises to manage anxiety, learning 'distracting skills' when trauma thoughts become intrusive, etc., while individual therapy might work on process of feelings and memories, identifying risks, etc.

67. Can CS-Group services be facilitated on-site 100% of the time?
Answer: No. CS-Group is subject to the 60% offsite requirement.

68. What are the specific distinctions between CS Services, Therapy/Counseling & Treatment Plan Development?
Answer: Please see Rule 132 Section 132.148 (treatment plan development) and Section 132.150 (services) for the service definitions of each.

69. Under CS-Individual, you suggest as a Core Service, working with an adult to join a church, temple, or mosque. Does this mean that staff will be expected to proselytize? Does the staff person call the leader of the particular faith community to ascertain if the community will accept the consumer?
Answer: This was provided as an example only. In all cases, a provider should assist the consumer in connecting to whichever natural support that is important to them (the consumer)--it is their recovery. To proselytize means "to induce someone to convert to one's own religious faith, or, to convert (a person) from one belief, doctrine, cause, or faith to another". This is not what we want to do. We do want to encourage consumers to reach out to their own faith if it is important to them.

70. Is it correct that a) there is no minimum number of CS hours required of any agency, and b) the requirement that 60% of CS services be provided in a "natural setting" is derived from the total number of CS service hours that an agency provides?
Answer: a) Yes, b) yes, the 60% in natural settings will be measured across the agency specifically to the individual service, i.e. CSI, CSG and CST.

71. In your PSR/CS example of the goal of finding a different place to live that will support recovery, the "CS - support (go with) individual(s) to tour available apartments, ask questions and request application" makes it look like CS does not need to be skill building. Isn't it inconsistent to just go with them?
Answer: In this example, the activity that would be billed is not just 'going with' the consumer. Rather, the staff member would bill only for those times when there was an active intervention such as coaching, prompting, discussing, reminding, etc.

72. If CS Services are expected to fluctuate rather than set services, how can we put frequency/duration on the treatment plan?
Answer: The frequency/duration should be set at a level that encompasses anticipated and medically necessary need for that treatment planning time period. Should circumstances or need change at such a level that this is inaccurate the treatment plan should be revised.

73. Will CS Services in an agency owned residential supported setting (820) be viewed as a "natural setting" and billable as "off-site"?
Answer: In Rule 132, 'off-site' is defined as "Locations other than provider sites, as described in this Part, where community mental health services are provided and that require the staff to travel from their usual office base in order to deliver the service. A place of residence that is owned or operated by a provider and occupied by a consumer will be considered an off-site location unless there is an office onsite that is the usual office base of the staff delivering the services."

74. Our Case Management consumers receive services by more than one case manager, as needed. We have a mobile crisis unit for after hours contact, including monitoring, counseling, help getting medications, etc., and not just crisis. Will the CS-Team or CS-Individual staff have to be contacted for each contact with our crisis staff, or only those contacts in which contact with CS-Team/CS-Individual staff would be beneficial (information regarding medications, crisis assessment, etc.)?
    Answer: Consumers enrolled in CS-Team are higher need consumers at greater risk for hospitalization so it would be good clinical practice for the Team to be aware of ALL services/interventions a consumer on their case load receives, regardless if it is a crisis or not. DHS/DMH believes that good communication among all providers serving a consumer is a best practice.

75. What would an on-site CS look like?
    Answer: The interventions/activities may be the same - place of service is the primary difference.

76. If more than 15 clients are present for a CS-Group encounter, can the group be done with two staff present? If not, why does this differ from the new PSR?
    Answer: Group size for CS-Group may not exceed 15 consumers regardless of the number of staff present. In CS-Group at least 60% of services must be provided in natural settings. PSR will be provided on-site only.

77. How will agencies not billing "at least 60% in natural setting" for CS services be penalized?
    Answer: You will be cited for non-compliance with the standard in a post-payment review.

78. Please give examples of CS by telephone.
    Answer: See service activities and interventions described in Ill. Adm. Code 132.150 subsections (e) and (f), and in the Service Definition and Reimbursement Guide.

79. If CS-Individual is provided via telephone call from provider in the office to client at home, is it considered "on-site" or "off-site?"
    Answer: On-site. Off-site services require that staff travel in order to deliver them.

80. Can you write a monthly service note for CS, as we do for TBS?
    Answer: No.

81. Can staff members (QMHP), bill HFS for Adolescent Group Therapy while simultaneously billing MRO for CS-Group (parent education & support) - same group time, same child's RIN?
    Answer: No. These services can be billed to either HFS or MRO but not for services provided at the same time to the same clients.

82. If a CS service is delivered at a Medicaid approved 820 Residential site, is it billed as on-site or off-site?
    Answer: It depends on whether staff are required to travel to provide the service and whether the service is provided in the staff office or in the client's home. Read the definition of "off-site" in Rule Section 132.25

83. Is it considered CS if you assist a client in applying/reapplying for entitlements, even if they do not need to re-learn the skill, but never had the skill due to cognitive deficits?
    Answer: No, it will be considered Case Management-MH.

84. Can you give examples of what activities are billable under CS-Group?
    Answer: See service activities and interventions described in 132.150 subsections (e) and (f), and in the Service Definition and Reimbursement Guide.

85. Can we bill for "dual" groups, open to both DMH & DASA clients i.e., CS-Group?
    Answer: No.

86. What if the CS-Group size is more than 15? Do you start a new group, split the group, or add additional staff?
    Answer: CS-Group should not exceed 15. Provider could start a new group.

87. Can a Therapy-only client have Community Support on the ITP to allow billing for activities that were formerly billed to Case Management, but no longer meet the definition of Case Management, e.g., assisting with transportation arrangements?
Answer: The consumer's needs should have corresponding services identified with goals on the ITP.

88. If a service occurs at several sites, e.g., school, agency, and in the community, can they be billed as off-site?
Answer: Off-site services are defined as services that require staff to travel in order to deliver the service. A service that does not require staff travel will be considered as "on-site."

89. Is the apartment of a client in a supported living program considered to be in a "natural" setting?
Answer: Yes.

90. An agency owns an apartment building, which is primarily used by "leasing" staff, with one apartment for use by case management staff as an office only while providing services to resident(s) in the building. This particular office is not used on a regular basis. Can those service occasions be billed as "off-site"?
Answer: Only if staff must travel to use the office and the office is not a certified site.

91. We have a supported apartment program within an apartment complex, where we also have a staff office. Clients lease apartments in their own name. The apartments are a "natural setting"; can we bill services provided in the client's apartment as "off-site", in spite of the fact that staff need not travel to engage with the client?
Answer: No, the services should be billed as on-site.

92. If we have supported living sites (aka: intermittent CILAs - not 24hr-supervised) already certified by DMH, must we continue to bill services provided there as "on-site"?
Answer: No. Services provided in a supported residential site may be billed as off-site if they meet the definition of off-site services.

93. Can a site be billed as both on-site (for staff whose office is located there), and off-site (for staff who travel to that location to provide a service?
Answer: No, not if the site is certified. Services provided in a certified site are always billed as on-site.

94. Our agency has a pilot DMH/DCFS collaborative TLP-MI program for 18-20 yr old DCFS wards. How would this living situation be classified, e.g., on-site, off-site, supported residential, home?
Answer: If the program is supervised (24/7) services will be on-site. If the program has staff for part of the day, services may be off-site.

95. Our clients rent apartments in two buildings next to each other. They are not CILAs, and each client rents their apartment independently; they are not certified sites. In one of the buildings, our agency rents an apartment solely as an office for a computer, allowing staff an area to do notes. Will the building with this office be considered "on-site", and the other "off-site"?
Answer: In both cases services will be considered "off-site" if staff travel to provide the services.

96. Is the "on-site" or "off-site" determination dependent upon how far away a residential site is from an agency office?
Answer: No. If service requires staff to travel in order to deliver the service, the service will be considered "off-site".

97. For agencies with several approved sites, but services are provided in schools or client residences, which site do you reflect?
Answer: The site where the service is provided.

98. Is a sign-in sheet required for CS Group?
Answer: You need to document group size. A sign-in sheet is one method for documenting that.

99. Does the 60% in natural settings apply to every client?
Answer: No, each of the community support services (CS-Individual, CS-Group, CS-Team) will be reviewed in the aggregate across the agency.

100. What is the staff to client ratio for community support?
Answer: There is no staff to client ratio for CS-Individual.

101. Are social events included in community support?
Answer: Only when there is direct intervention with the client. It does not include observation, providing supervision or milieu therapy.

102. On the ITP, do we have to distinguish between the four kinds of community support or can we just put community support?
Answer: You need to distinguish between the different kinds of community support.

103. If we provide only CS & PSR, when a current consumer is determined by LOCUS to need ACT, do we refer them now?
Answer: If ACT services are available and readily accessible the individual should be referred to the level of care needed. Remember, however, the LOCUS is not the only determination of a client's level of care, and participation in ACT requires DMH authorization.

104. We are working with the family of a small child, age 0-5, providing skill building in order to assist the client in the development of functional, interpersonal, family, coping and community living skills that are negatively impacted by the client's mental illness. Can the skill building be done with the family of the child so they can develop their skills to assist their child, whose mental illness is negatively impacting the child's functioning? Can the skill building only be done with the child? Can this be billed as Community Support Individual or should it be billed as family therapy?
Answer: Providing CS to the family is acceptable, but it must clearly be for the benefit of the child in response to his/her mental illness. Whether it is therapy/counseling or community support depends on what intervention is actually being provided. Remember, all Rule 132 services must for the benefit of the client.

105. Our scenario is that we have a worker who primarily bills case management transition linkage and aftercare for consumers who are being transitioned out of nursing homes. Once they are out, she is required to do follow up that may include some skills teaching, which is CSI. Can non-CST staff bill CSI to a CST consumer?
Answer: The only time CSI may be provided to someone in CST is during the 30 days that the consumer is either transitioning from CSI into CST or when the consumer is transitioning from CST to CSI. Otherwise, no.

106. What do you mean when you state that we cannot directly provide services under case management?
Answer: This point was intended to highlight the difference between CS and CM. CM focuses on doing things 'for' a consumer (getting them their benefits, finding them housing, etc), while CS is an active intervention 'with' the consumer to build their capacity and teach them how to access resources.

107. How would we bill telephone support to a client that is an unplanned intervention; it wouldn't be individual therapy. For example, the client calls up, with a situation overwhelming them, not a recurrently threatening crisis to the point of hospitalization, but they are overwhelmed to the point where they may experience increased symptoms without supportive service. Is this Community Support, Case Management, or Crisis Service?
Answer: Bill this service as Community Support-Individual.

108. Most counseling services may only be delivered at pre-scheduled times, so how do you bill staff intervention for anger management, to defuse a potentially aggressive client, in a community setting?
Answer: The service can be billed as crisis intervention or community support.

109. Can one team do both PSR & CS?
Answer: Yes, one team could offer PSR and also provide CS-Individual and CS-Group. CS-Team must be a dedicated team however.

110. Must PSR service staff have a caseload, like in CS?
Answer: No. CST is the only CS that has a prescribed caseload.

111. In regard to PSR & CS, can one agency provide PSR & another provide CS? For example, in our county the health department provides case management services to individuals & gives them the option of receiving PSR there, or from their choice of 2 other agencies.
Answer: No, in order for an agency to be certified as PSR, they must also have CS.

112. Can you combine PSR & CS services?
Answer: Providers providing PSR must also provide CS services.

113. Is PSR a stand-alone service or must it be a part of CS Services?
Answer: In order to be certified in PSR, a provider must also be certified for CS services.

114. Are CS services offered as a stand-alone program, or only as a part of PSR, or both?
Answer: CS services may be offered separately from PSR. PSR must include CS however.

115. Is it correct that there is no required percentage/expectation for how much time a consumer must be in PSR -v- engaged in CS services, that the ratio of time is based on individual needs?
Answer: Yes.

116. A consumer-run snack shop is in our agency building and currently is part of our PSR program. Will this now be considered a CS Service because the consumers have created a natural environment & are practicing their money-handling, social skills, etc., there?
Answer: A consumer run snack shop would not automatically be billable as PSR or CS. In order to bill for a service, it must be a direct intervention between a staff and a given consumer that meets the service requirement in 132.150 and is on the ITP. The time providing this intervention is the time that may be billed.

117. Can an individual receive PSR services, CS-Team services, and CS-Individual services concurrently?
Answer: Only 1 service can be provided, and thus billed, at a time. A consumer may be receiving CS-Team and PSR. A consumer may be receiving CS-Individual and PSR. A consumer cannot receive both CS-Team and CS-Individual except during authorized periods of transition to or from CS-Team.

118. We do DBT, which seems to fit into more than one category. I had it in PSR because of the skills training, CBT aspects, and frequent need for Community Support, supporting the skills and prevention of symptoms, often during off-hours. Medicare considers it Group Therapy. Somewhere in the trainings, it was split out as an outpatient specialty group. Can I put it into PSR Services? On the notes, can we call it PSR/Group Therapy to please both MRO and Medicare?
Answer: Under the Rule parts of DBT could be billed as Therapy/Counseling, Community Support, and/or PSR services. When billing both MRO and Medicare for a given intervention, we recommend you indicate the payor next to each service title, e.g., PSR (MRO)/Group Therapy (Medicare). Additionally, care must be taken to not bill multiple payers for the same service.

119. Will PSR consumers in nursing homes receive CS-Individual or Group in the nursing home and be considered in a natural setting?
Answer: Community support services may be provided to individuals in a nursing home. The nursing home is not considered to be a natural setting. Services must be delivered outside the nursing home in order to qualify as in a natural setting.

120. Activity in the community to practice skills learned in PSR - does it count toward the 25 hours per week?
Answer: No, that is community support not PSR.

121. Since PSR service now requires Community Support, how does this affect the twenty-five hours of PSR?
Answer: Community Support does not affect the twenty five hour PSR requirement.

122. Can a person involved in the PSR service also receive CSG?
Answer: Yes, that is the community support service (either CSG or CSI) that should be provided in conjunction with PSR.

123. Our current drop-in center is operated by peer counselors, who bill for socialization, developing self-directed recreational and leisure skills, coping skills development. These are paid prosumer staff. PSR is provided in the same building. The prosumer staff meet RSA requirement. The skills are provided in a group format; however the start and end times are not regularly scheduled times. Are these groups billable?
Answer: These services may be billable if they meet the service requirements of Community Support. Interventions to develop socialization skills may be billable, social activities are not billable.

124. Clarify the difference between off-site and natural setting. If the services are provided in residential does it count toward the 60% in natural setting?
Answer: No. Community Support services provided in Supervised, CILA and Crisis Residential programs are Community Support Residential. Community Support services in Supported Residential programs may be Community Support Individual/Group/Team and may be either onsite or offsite.

125. Our program conducts an evening program that may be a combination of PSR and CS. Several peer sponsors organize the program, which may consist of playing games, which promotes developing friendships. The peer sponsors are staff and there is also one staff involved. All staff are interacting by playing games (cards) with consumers.
Answer: This is not a billable activity as described. The only billable time would be when staff interact directly with consumers providing a direct service intervention that meets assessed need and is identified on the treatment plan.

126. Please expand on community support "appropriately credentialed staff".
Answer: Community Support can be provided by RSAs, MHPs, QMHPs and LPHAs.

127. If the client to staff ratio is 15:1 in PSR, then is it acceptable to have twenty consumers and two staff? Could CSG be provided this way?
Answer: For PSR, this is acceptable in the provision of on-site skill building sessions. For Community Support, the Rule specifies that the group must be between two and fifteen people. The intent comes from consumer feedback, conducting a group of thirty does not make consumers feel good about Recovery. Feedback from consumer focus groups recommended a limit of fifteen to a group, even though this is still a large group. Any time you bill a service, provide documentation of evidence of how many were in the group.

128. If you have a group over fifteen, as long as we document the number of staff to number of consumers and we have at least one staff per every 15 clients, is this acceptable?
Answer: For PSR, yes. For Community Support group, the limit is strictly fifteen persons regardless of how many staff. The rule does not allow it to be a staff person for every fifteen clients.

129. BALC noted that groups cannot be larger than fifteen? So how does that impact large social events?
Answer: Community Support Groups must range from two to fifteen consumers. We recognize that social events that include a large number of consumers may provide opportunities for consumers that are beneficial; however, what is billable during this time would likely be the 1:1 interventions between staff and consumer. Billing the entire day for large group events is not allowable. Billing Community Support Group for all who attend is not allowable because there is not active intervention for all (for example, at a picnic).

130. When a provider subcontracts community support-individual, does the subcontractor have to be Rule 132 certified?
Answer: Yes. A provider may subcontract for services authorized by Rule 132. All subcontractors must be certified to participate in the Illinois Medical Assistance program and enrolled as a provider with HFS. ... For the purposes of this subsection, a contractual employee or an individual on contract is not considered to be a subcontrator." IAC 132.145 (b)

131. According to the rule, it appears that the expectation is for 60% of each service (CS-Individual and Group) to be provided off-site. We're having trouble understanding the rationale for holding the majority of community support groups off-site. Since group services tend to be didactic we will need to hold the groups in some central location. There does not seem to be an advantage for enhancing client independence to hold group sessions in client homes or to find a public venue such as a library meeting room or church. Our office is centrally located and is more convenient for clients to attend a group. Our understanding of Community Support is that the portions of the group work that involve practice in real life situations, such as learning to ride the bus or working on social skills in natural environments will, of course, be provided in natural settings and that this is the essential feature of community support as an intervention. Given, however, that a lot of work must be done with the clients in preparing them for those community ventures we do not see that it is reasonable to spend a full 60% of CS Group time in off-site settings. It seems reasonable that a larger percentage of time providing Community Support Individual should be held in the community. Can you explain the rationale for requiring 60% of each service to be provided in the community, or are we misunderstanding the rule? Is it possible that 60% of ALL community support services should be held in the community (individual and group combined)? This would make sense and be very reasonable.
Answer: You are correct that the 60% in natural settings will be determined by specific service, e.g., 60% of CS-Individual and 60% of CS-Group. Community Support Group services consist of mental health rehabilitation services and supports for children, adolescents, families and adults necessary to assist a group of clients to achieve and maintain rehabilitative, resiliency and recovery goals. The service consists of therapeutic interventions delivered by individuals or multi-disciplinary teams that facilitate illness self-management, skill building, identification and use of natural supports, and use of community resources.

132. A counselor has identified parents of children she is seeing as having similar needs and has offered to conduct a group for the parents of the children she is seeing. The parents are not the registered client. The children are the registered clients. Can services to the parents be billed as collaterals? We're thinking that the group would be a community support group as most will be skills training.
Answer: Families are critical participants in the provision of mental health services to children. They are collaterals. The 132 requirement is that all services provided must be for the mental health needs of the registered client. If the other members of the family have mental health needs of their own, they should become clients. Additionally, services provided to families that are not related to the mental health needs of the client, are not billable as any 132 service. (2/22/11)

133. How should we bill for parenting skills groups for families of children who are DMH funded? At the moment, many of our child consumers' parents have a need for a more skill development group format. Can we bill possibly community support group under the child's case for the parents(who do not have open cases) who are receiving essential parenting tools & a curriculum-based "emotional-coaching" training program? This is a 10 week initiative that we would like to establish. (The children are being seen in group therapy at the same time). Should we possibly interpret this clinical scenario as case-management in terms of linkage with the necessary parenting skill development opportunities for the family?
Answer: Skills taught to parents must clearly relate to the mental health needs of the children. Teaching of general parenting skills is not billable under Rule 132. Additionally, all parents in the group must have a child with similar mental health needs that will benefit from participation in the group. These groups are most likely Community Support Group and not Therapy/Counseling. Yes, service to the child and to parents can be provided and billed at the same time. They, of

course, cannot be provided at the same time by the same staff. This is not case management. (2/22/11)

134. Since the consumer's apartment is considered the natural setting, can community support services provided within the consumer's HUD apartment be billed as community support individual - off-site and can community support services provided within staff office be billed as a community support individual or residential - on-site?
Answer: No. (9/1/11)

135. What residential settings are considered "natural settings"?
Answer: Only residential sites that are controlled by the person living there with a lease that gives them full rights of tenancy with the ability to decide whom they live with, when they come and go, who is invited to visit, how the place is furnished and decorated, etc. Sites that are CILA or supervised residential are not considered natural settings. (6/1/13)

136. What Rule 132 service would be most appropriately used for a multi-family parenting group that is focused on parents learning an evidenced-based behavioral health curriculum that will help parents address their child's mental health condition and support their child's recovery?
Answer: We appreciate your using evidenced-based services. Please remember as you provide this service that you may not be providing a general parenting group, but must be addressing the specific mental health needs of the children per their treatment plans. It is important that you assure and document that what you're billing matches the Rule 132 definition of the services. However, from your description, this seems most likely to be Community Support - Group. (6/1/13)

137. We are putting together a Parent Community Support group/children support group; one class will have the parents and the class next door is for the kids. Can we bill for both groups under the child and bundle the hours? Also, if two parents come together can we bill for both parents for that group?

Answer: Community Support Group may not be billed for the same person twice during the same period of time. In a group with families, each family unit counts as one person because all services provided must be for the benefit of the client (child) and each family unit is tied to only one client (child). (6/1/15)

138. May Community Support Individual, Group or Residential be provided along with Community Support Team?

Answer: Community Support Individual, Group or Residential may only be provided to someone receiving Community Support Team under the following conditions: A) In accordance with an ITP for 30 days to facilitate transition to and from CST services, or B) While a client is receiving services in a residential facility designated by the public payer for the purpose of stabilizing a crisis. All services provided must appear on a current ITP. (6/1/15)