PSYCHOSOCIAL REHABILITATION

1. Can PSR services be provided at any certified agency site? And do they have to be twenty-five hours?
   Answer: The Rule does not say there has to be twenty-five hours of service available at any one site, so PSR can be provided at multiple agency sites. PSR service must be a regularly scheduled event.

2. How detailed does the PSR application need to be for groups?
   Answer: The narrative description for groups needs to demonstrate that the group is designed to provide skill building. This can be accomplished in two to three sentences in a paragraph.

3. We would like to add a problem solving activity that focuses on planning a garden, and a money management group on the cost of planting a garden as a spring/summer activity, both of which will result in the planting, maintaining, and harvesting of a garden. Does this sound acceptable?
   Answer: Be sure to develop groups that meet identified needs and make sure that the treatment provided relates directly to the assessed need. Look at assessed needs, then develop program goals/objectives/lessons that address those needs and make sure progress notes stay focused on the mental health treatment.

4. Is there a daily maximum billing for PSR services; i.e. 5 hours a day?
   Answer: No. The amount of PSR service a consumer receives is based on the consumer’s assessed needs, desired services and outcomes and treatment plan.

5. Can two different agencies provide PSR services to the same client? Our agency and another share a client and want to offer PSR services at both sites (addressing different goals and objectives for identified needs with client preference). We are working on an integrated plan to direct the services. As long as the services don’t overlap in time and duration, are the services billable?
   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.

6. One of our agencies wants to split their PSR program during the summer by providing the program at one building on three days and another building on the other two days. They want to do this because their Teen REACH program will change hours of operation during the summer and they need the space in the main PSR building. Do you see any problems with this? Would this be a certification site issue?
   Answer: The only concern we would have is consumer access. If the region is comfortable that those served will continue to have access to the services they need, then this would be acceptable. It is assumed that both sites are currently certified sites. If not, the new one will need to become certified.

7. We have a consumer that lives in an Intermediate Care Facility (ICF) and attends our PSR Program on site during day hours. He is not receiving PSR services in the ICF, and states that he does not get any type of group support or treatment at the ICF and does not work with a case manager there. Can we bill PSR services for this consumer?
   Answer: If the consumer has an MI diagnosis, you may provide Rule 132 services to this person. Everything that applies to other Rule 132 services apply in this case. The consumer must have been assessed and must have an ITP that reflects the identified needs and desires of the consumer. PSR, if meeting the assessed needs, i.e., being medically necessary, must appear on the ITP. The provision of services must be documented according to Rule 132 requirements.
8. Due to inclement weather, an agency decided to cancel PSR. In doing so the PSR staff then went to their residential homes and provided PSR skill building groups there. The groups were provided by PSR Staff (non-residential) to the consumers in residential. How would they bill this?

Answer: Is the residential site a certified site? If yes, then it would be PSR.

9. How are we to correctly document and bill a PSR group of 15+ persons that is run conjointly by 2 staff of differing credential levels? EXAMPLE: Group has 20 members attending. Two staff conjointly run the group with one being a Q, the other a M. Session lasts for 45 minutes. Can the billing be split in half with 10 billed at the Q rate and 10 at the M rate? Does whoever writes the note in a chart bill at their rate so if the Q writes 15 notes and the M 5 notes there would be 15 Q rate bills and 5 M rate bills? Does the note have to have both clinical staff sign it?

Answer: The service should be billed at the rate of the staff person who is in charge of the group as demonstrated by her/his documenting what took place in the group and signing off. The entire session should be billed as one and not divided.

10. What does the term "educational and vocational goal setting and attainment" mean and, is this term in the rule?

Answer: Rule 132.150 j) describes PSR with the following: "The focus of treatment interventions includes skill building to facilitate independent living and adaptation, problem solving and coping skills development. The service is intended to assist clients' ability to: A) Live as independently as possible; B) Manage their illness and lives with as little professional intervention as possible; and C) Achieve functional, social, educational and vocational goals." The key part of this is that it is skill building to facilitate independent living and adaptation, problem solving and coping skills development. Medicaid will not fund services designed to teach specific educational processes such as reading, math, etc. and it will not fund training provided to assist a consumer in learning specific job skills. PSR is to teach consumers skills such as managing their anger that might interfere with their ability to learn or maintain a job.

11. Can a consumer who receives PSR group skill building services also receive therapy/counseling group services in the same week?

Answer: Yes.

12. Is the 1 to 15 ratio for groups, only? Does Rule 132 require that a 1 to 15 ratio also apply to caseload per FTE?

Answer: The ratio applies to PSR groups only.

13. In regard to the number of clients allowed per FTE, in filling out the application, how do I calculate the hours that we have staff in PSR and also CS-Individual/Group? Can I list the seven current PSR Staff as full time in PSR and can they then also provide CS-Individual/Group? We will be having some clinicians providing a PSR group or two. Can I then count them as full time in PSR? If we are able to do this, we can provide PSR services to more of our clients. Is anyone going to look at the staffing pattern to see if those folks provide other Rule 132 services and then say they can't be counted as PSR staff?

Answer: The ratio of 1 to 15 for PSR is a ratio for groups. There is no requirement in rule 132 that staff providing PSR may not provide other services. There are also no specific requirements (other than the program/clinical director being on-site at least 50% of the time) for number of hours each staff person must spend in PSR. Staff are only full time in a program if they spend all their working hours delivering that particular program/service.

14. Is the requirement of a staff to client ratio of 1:10 intended to be maintained on a daily basis or for the overall program enrollment, which could vary daily depending on the number of clients participating on a given day?

Answer: The PSR ratio of 1:15 is for PSR groups only.
15. According to IAC 132.150 (j)(4)(C), "The clinical supervisor or program director shall be on-site at least 50% of the time. If a provider has multiple sites, the clinical supervisor or program director must be able to document a consistent schedule that includes on-site time at each location." Does this allow for operating PSR at two separate locations with a different PSR clinical supervisor at each site, each spending 50% or more of their time at their designated sites, both overseeing PSR services, the staff and resources tied to that service?

Answer: As long as both supervisors are QMHPs, there is nothing in Rule 132 prohibiting more than one clinical supervisor/program director.

16. Can we bill PSR group for therapies that include: listening to a piece of music; watching a TV/movie scene; reading an article/book; or viewing a piece of art for a specific period of time (10-15 min) and then discussing what the consumers were exposed to? The treatment plans would state that these things will be used to introduce therapeutic discussions, and the facilitator would be a MHP or QMHP. The discussion would last for an equal or greater period of time than was spent on exposure to the medium.

Answer: Our basic policy is that we will not pay for a PSR group to watch a movie or read a book. We will pay for the discussion directed toward individuals' goals, but not the movie time. We recognize that it is best-practice to engage people in learning and expressing through a variety of media. For good group process, the leader should not do all of the talking or presenting. Part of engaging a group is sharing roles. The leader is responsible for facilitating interactions and directing activity and discussion toward achievement of the goals/objectives in individuals' treatment plans. The group leader must be present while the media is presented so that they can be attentive to the responses. Therefore, media clips or segments can be used for short periods of time to facilitate discussion toward achievement of goals/objectives in individual treatment plans.

17. We review our PSR Skills Training Groups quarterly and change them according to the consumers' needs. In order to accomplish this, we close down PSR groups for one week between each quarter, assess each consumer's needs and assign them to the next appropriate group. For one week each quarter we would not meet the required 25 hours per week of PSR Scheduling needed for certification. Is our quarterly closing for assessment purposes acceptable?

Answer: Let us begin by emphasizing the importance of shifting the locus of care to the community. During the break, and in addition to, PSR, it would be positive to involve the consumers in Community Support Services where they would have an opportunity to transfer and apply what they have done in PSR to their everyday lives in the community. If PSR is medically necessary on a weekly basis for the consumers involved, it raises the question of why a required service is unavailable for an entire week. However, if the consumers do not need PSR on a weekly basis, not receiving it is not an issue. The delivery of services should always be based on the needs and desires of the consumers and be intended to promote and support their recovery.

18. Should all PSR clients receive CS-Group or CS-Individual?

Answer: Community Support is important as clients practice the skills that are learned in PSR. The extent of Community Support depends on the client's goals and objectives.

19. If individuals reside in long-term care facilities, have no potential for independent living due to health, age, severity of mental illness, etc., should they be enrolled in PSR?

Answer: We hesitate to give a definitive answer for all circumstances. The determination should be based on good clinical judgment and the goals and objectives of the client.

20. When providing CS-Group, only time providing direct staff intervention interaction is billable. Is that requirement the same for PSR Group?

Answer: Yes.
21. The PSR service program director must be a QMHP, on-site 50% of the time. Must it be the same Q every day? If the program director cannot be at the site and another Q is available, would that cover the terms of the Rule?
   Answer: It must be the same Q each day unless the program director is on vacation or sick. Then per 59 IAC 132.150 j) 4) A), C), D), another Q must be designated as the fill-in.

22. Can a consumer stay in PSR longer if they want?
   Answer: It depends on the assessment of the person's needs. The consumer may need assistance in identifying ways to meet their personal goals.

23. Does a consumer have to receive CS before getting PSR?
   Answer: No.

24. Is CS integral to PSR, i.e., you can't provide only PSR?
   Answer: That is correct. If you provide PSR, you must also provide CS. CS is the community based vehicle for the consumer to practice, apply and integrate the skills and supports learned in PSR.

25. Since CS is integral to PSR, do the PSR services count toward the 40% onsite services for CS?
   Answer: No. Only CS services are counted in the percentages.

26. How much CS is needed to practice PSR?
   Answer: That depends on the individual and their ability to transfer the skill to a community setting.

27. How do you practice skills in the community when the person is homeless?
   Answer: In the community does not necessarily mean in the person's home.

28. Are there a minimum number of hours that a consumer can participate in PSR?
   Answer: No, the consumer may participate according to their assessed needs. The PSR service is required by Rule 132 to be available at least 25 hours per week, 4 days per week.

29. A consumer chooses to participate in a cooking class, even though he/she knows how to cook. Is that billed as PSR?
   Answer: No. The skill has already been acquired, and it would not be an appropriate goal on the treatment plan. The service would not be considered to be medically necessary. The consumer may participate in the class but their participation is not billable to Medicaid.

30. CS Group and PSR groups - what is the difference?
   Answer: PSR groups are agency-based only. PSR is a structured program specifically targeted to individuals who need more support and structure and who might otherwise not access a group. CS groups can be held in the community or in a facility and the CS groups may be focused on activities other than skill building.

31. What is the relationship of PSR service to the treatment plan and a person’s goals?
   Answer: Specific activities billed for an individual while in PSR must be based on assessed needs, relate to a goal/objective on the treatment plan, be specified as an intervention on the ITP and reflect activities consistent with the service definition.

32. Can you bill PSR in a community setting?
   Answer: No, PSR service is facility based. Services in the community are most likely to be CS.

33. Is a module or curriculum required in the PSR service?
   Answer: No, but research indicates that a curriculum focuses activities on "next steps" and recovery principles.
34. Can PSR be a supplement to therapy?
   Answer: Yes, if the consumer needs some skills training or other activities that are integral to the PSR service.

35. How is PSR goal setting coordinated with the case manager, and how will these goals be incorporated into the treatment plan?
   Answer: The consumer must have a single, unified treatment plan that reflects all services within an agency that the consumer is receiving. An agency may elect to have a case manager, community support staff, or other staff be designated as the primary coordinator though it is expected that PSR would NOT be this point of coordination because it is not community based.

36. Can skill building occur in a person's home?
   Answer: Yes, skill building is an activity incorporated in CS. It would not be PSR because the PSR service is facility-based.

37. A number of your examples in training are related to social activity. In post-payment audits, DHS staff has told us that Medicaid does not recognize these activities as medically necessary.
   Answer: The treatment intervention must be related to a deficit, be identified as needed in a mental health assessment and on the consumer's treatment plan. Watching clients in a social setting is not billable.

38. Do two distinct staff have to do PSR and CS, or can one staff do both?
   Answer: The same staff can provide both services. It depends on what is clinically appropriate.

39. Is it true that an ACT consumer cannot receive PSR services?
   Answer: That is correct. ACT is a comprehensive mental health services, and the ACT team should provide skills development. The rule does allow for authorization of services other than ACT during a clinical transition to or from ACT.

40. What is the staff to consumer ratio for PSR?
   Answer: The staffing ratio cannot exceed one FTE staff to 15 consumers within a single group.

41. Can we bill exercise to PSR or CS if the goals are weight loss & increasing activity?
   Answer: Exercise may be billable to PSR or CS if it relates to the specific consumer's assessed mental health needs (documented on the assessment), has a specific goal/objective on the consumer's treatment plan, and involves direct interaction between the billing staff member and the consumer. The client exercising on his/her own is not billable.

42. Are consumers of Shelter Care Homes eligible for PSR if they are not in CS but in Med Monitoring; documented medical necessity being maintenance of functioning level or prevention of decomposition?
   Answer: All PSR services must have a CS component.

43. How can one make day-to-day changes in a treatment plan when it must be staffed & signed off by the doctor?
   Answer: Rule 132 does not require that treatment plans be staffed and signed off by a physician. Treatment plans must be reviewed and signed by a Licensed Practitioner of the Healing Arts (LPHA) which covers more disciplines than just a physician. Treatment plans should be formally updated when there are significant changes in the consumer's circumstances or in treatment approach/services.

44. Can PSR services be used by consumers in an Outpatient Therapy Program?
   Answer: Yes. All requirements for program certification and consumer medical necessity are applicable.
45. In small agencies, staff may provide PSR and/or CS. For example: PSR is 9-3 M-F. CS-Group is on Wednesday, 12-3. With this schedule, one would not be able to provide PSR 25 hrs/wk. How could we maintain 25 hours of PSR per week without adding staff? Will the state pay for the added CS staff?

Answer: The schedule noted above provides 25 hours of PSR per week.

46. Some MH consumers isolate themselves and have few friends. If your CS group takes them out to eat (for peer-interaction), or rummage sales (for budgeting money), or bingo (to socialize), are any of these activities billable as skill-building services?

Answer: It is possible that some time during these activities may be billable for some consumers. The need must be reflected on each billed consumer's current assessment, a corresponding goal must be on the treatment plan, and only direct service time is billable, i.e., cannot bill for driving time, or peer interaction when a staff member is not interacting/directing intervention.

47. If PSR compliments CS, what do we do with outpatients who receive only doctor/nurse/therapy but drop-ins for services such as money management, but does not qualify for CS at the time?

Answer: If a consumer has needs that include activities within the CS definition, CS may be added to their treatment plan and the appropriate billing made when the CS service is provided.

48. Does PSR still include the concept of Therapeutic Milieu?

Answer: No. An active intervention on the part of a staff directly with the consumer is the allowed billable activity.

49. An example used during the PSR presentation was that several consumers have a goal of losing weight related to their medications. We have repeatedly had surveyors disallow this type of skills work, the reasoning being that it is not essential for remaining psychiatrically stable in the community. How does Rule 132 respond to this?

Answer: This is not a Rule 132 issue but rather relates to a discussion of what constitutes medical necessity. If an intervention is directly related to a symptom or need that is caused or exacerbated by a mental illness, it is generally considered medically necessary.

50. PSR and CS are very similar services - why have both? Won't the similarities cause confusion in both provision and billing?

Answer: PSR and CS have very discrete differences. PSR is a facility based service targeted towards consumers with greater need who benefit most from increased structure. CS is a highly flexible service which should be delivered predominantly within a natural setting.

51. Is there a time/hour limit on PSR services?

Answer: No.

52. Please clarify how an individual can go into and out of PSR as needed.

Answer: A consumer may be referred to PSR for a discrete time period to learn a set of needed skills, (nutrition, money management, etc). At a different time in their recovery the need arises for a different or additional set of skills, they could be referred again to PSR for a time limited period to gain those capacities. During other periods of time, they could receive other 132 services as medically necessary.

53. As CS & PSR services strive to make the consumers' clinical home in the community & 60% of CS services offered in natural settings, will DHS-DMH take any steps toward assisting agencies in recouping their increased transportation costs?

Answer: DHS/DMH recognizes the increased cost of providing services in the community. One method to offset this is the approximately 17% higher rate paid for off-site services.
54. The "development" of skills is cited in the PSR service definition, which is habilitative rather than rehabilitative. To be "rehabilitative" we must demonstrate that a person at one time had the skill - how shall this be documented?

Answer: Services and interventions should relate to a psychiatric diagnosis, needs as documented in the assessment, on individualized treatment plans, with supporting progress/contact notes.

55. How can staff go about meeting the state's requirements for CS for individuals enrolled in a PSR program when that is the only treatment?

Answer: DHS/DMH believes that the practice/implementation of skills learned in PSR should be done in the natural setting, i.e. community support. Treatment options should expand.

56. What are the specifics regarding documentation requirements of PSR for clerical supervisors?

Answer: (DMH assumes that the question relates to clinical supervisors, not clerical supervisors) The QMHP's schedule will be compared to the number of hours that the PSR services are available, and it should reflect that the QMHP is on site at 50 percent of the time.

57. 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.

58. Must PSR service staff have a caseload, like in CS?

Answer: No. CST is the only CS that has a prescribed caseload.

59. 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.

60. Can you combine PSR & CS services?

Answer: The PSR model requires that a program offering PSR must also provide CS services.

61. How does the model account for the specific needs of an MH consumer in CS or PSR services with a co-occurring DD diagnosis?

Answer: There is no change from prior Rules in this area.

62. Since Vocational Engagement clearly indicates workshops are not eligible, can those skills taught in work settings in facilities be considered under the PSR definition?

Answer: No.

63. Is PSR a stand-alone service or must it be a part of CS Services?

Answer: In order to be certified in PSR under the new model, a provider must also be certified for CS services.

64. Can PSR/ACT be used with the C&A populations?

Answer: PSR and ACT service definitions are written for consumers 18 years of age and older.

65. Must we have a CS-Team set up in order to provide PSR services, or, may we provide CS-Team, Individual and/or Group on as-needed basis?

Answer: CS-Team is a separate and distinct certification and is not required to provide PSR. PSR certification does require CS.

66. 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.
67. How can a limited staff set 90-100 PSR consumers daily out into the community?
Answer: There is no requirement that all consumers go out into the community daily. Staffing should be at an appropriate level to meet the needs of the consumers served.

68. 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.

69. 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.

70. How do we implement Community Support in order to have PSR, without increased funding and staff?
Answer: PSR staff may provide CS services outside of the 25 hours program operation. This would not necessitate increased staff costs. In addition, if you have case management or other staff in your agency, they may provide CS to your PSR consumers and meet the requirement as well.

71. Is there a minimum or maximum time for individual therapy?
Answer: Therapy is not part of the PSR service and it cannot be counted as part of the PSR twenty five hour schedule. There is no PSR service requirement that an individual has to have therapy/counseling. There is no minimum or maximum limit for therapy.

72. Within PSR, what type(s) of services can be funded as part of pre-educational and/or pre-vocational services?
Answer: Pre-vocational activities are designed to develop habits and routines that assist the person to function with a mental illness and potentially pursue work as a goal. Examples: skills development of general work habits, including punctuality, following directions, getting along with co-workers and supervisors, etc. It also includes sessions to identify and address concerns with work. Pre-educational activities are designed to develop habits and routines that assist the person to function with a mental illness and potentially pursue education as a goal.

73. If a consumer is hospitalized for psychosis upon discharge from the hospital and there is no longer an intensive program, would he/she be transitioned into a PSR group?
Answer: Mental health intensive outpatient services continue to be included in Rule 132. Depending on the clinical needs of the consumer, PSR could be appropriate, as could other services specified in the Rule.

74. How does an agency meet the PSR staff:client ratio of 1:15 if a percentage of PSR clients attend only 1-2 groups per week? This creates a potential for staff underutilization, and insufficient billing to support the program. Conversely, if a staff person from another program comes in 1-2 times per week to run a specific PSR group, can this person be included in the FTE ratio for PSR staff (counted as part of 1 FTE)?
Answer: The 1:15 ratio specified in Rule 132 is intended to apply to the staff to consumer ratio within PSR group.

75. Is there a ratio for "available" services between group and individual PSR services?
Answer: Up to 5 hours of the minimum 25 hours of available PSR services can be carved out as "open door" time for flexible provision of individual PSR services. The ratio of individual to group PSR service provided to a specific consumer is to be based on clinical need and consumer choice.
76. Is it possible that if in one day, a client goes to 3 groups for 3 hrs, and covers 3 different PSR activities, e.g., symptom mgt, stress mgt & social skills development, that staff could bill for 3 hrs., & talk about how the client responded to PSR goals in those 3 hrs. & what services the staff provided during that time?
   Answer: Yes.

77. Can PSR providers bill other Rule 132 services if certified to provide them?
   Answer: Yes.

78. We currently have about 14 clients working on-site from 2-14 hrs/wk, in a Supported Employment Program. They are on the agency payroll, being trained in pre-vocational skills while working in the food pantry, or as peer aides at our drop-in center. Neither is competitive off-site employment. While at work, they are instructed in skills such as following instructions, being on time, coping with symptoms, relating to others appropriately, assisting other clients with appropriate socialization, problem solving, and staying on task. Can this be billed as a PSR service or Job Retention Supports?
   Answer: The staff interventions you describe appear to be facility-based and directed toward pre-vocational skills. As such, they could be billed as PSR services by an agency certified to provide PSR. As a caution, only the periods of time during which an active intervention is delivered by agency staff should be billed.

79. Must all PSR services be curriculum-based with documentation, including what curriculum was used and what portion/lesson was covered?
   Answer: No.

80. 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.

81. Can PSR services be delivered in conjunction with any other Medicaid activity?
   Answer: PSR can be part of a treatment plan that includes other Medicaid mental health services, except for ACT. Consumers cannot receive both ACT and PSR except during authorized periods of transition to or from ACT.

82. Can PSR services be delivered in conjunction with ACT?
   Answer: Consumers cannot receive both ACT and PSR except during authorized periods of transition to or from ACT.

83. Can PSR be done off-site?
   Answer: No.

84. Does PSR require structured classes delivered in a group setting, including clients with the same/similar goals, e.g., basic cooking, money management, etc.?
   Answer: No, structured classes are not required. The Rule requirement is that they be provided in an "organized program through individual and group interventions". This ensures that PSR services can be used to help individuals meet a variety of recovery goals. Consumers within a group can be working on different goals as long as the group is an appropriate intervention to assist the consumer with meeting his/her goal(s).

85. Can we bill for a 4-6 hr unit of PSR group services addressing several of the consumer's individual goals, i.e., pre-vocational, socialization, etc?
   Answer: You can bill for services provided to a client. It does not include rest periods or meals.
86. Since MISA and DBT outpatient groups are "specialized" groups, can they be billed as Therapy/Counseling groups?

Answer: MISA and DBT groups can be billed as Therapy/Counseling Groups if they meet Rule 132 requirements for therapy/counseling.

87. 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 new 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.

88. Can we put our several client-led groups onto the PSR Services schedule and count them toward the 25 hrs/wk?

Answer: No.

89. 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.

90. Is skills training, e.g., DBT, allowed as Individual Therapy and/or Group Therapy/Counseling component, and what are some examples of appropriate outcomes?

Answer: DBT is allowed as individual or group therapy/counseling and should be billed as therapy/counseling. Skills training, that meets rule 132 requirements for PSR service can be billed as PSR Service.

91. For agencies with more than one site: 1) Must a PSR clinical supervisor/program director be at all sites 50% of the time? 2) Must PSR services be provided 25 hrs, 4 days/wk at all sites? 3) Must there be a MISA experienced staff person at all sites?

Answer: 1) The QMHP must be present at a PSR site at least 50% of the operating hours, or a minimum of 12.5 hours of the required 25 hours per week. During the hours that the QMHP supervisor is not onsite at the PSR site, the supervisor must be available to PSR staff by phone, or another QMHP must be designated to be available to staff in person or by phone. 2) The QMHP must be onsite 50% of the operating hours in at least one of the provider's sites. 3) It is expected that if multiple sites exist, the QMHP supervisor will be able to document a consistent schedule that includes onsite time at each location.

92. The PSR service definition states staff must be co-occurring capable. There is no definition of "capable" in the new Rule. What does it mean?

Answer: 59 Ill. Adm. Code 132 states that each PSR program shall "include at least one staff person with documented experience or training to provide services and interventions to clients with co-occurring psychiatric and substance abuse disorders." The rule does not use the term "capable."

93. 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.
94. Can the QMHP work in another program since they are required to be onsite only 50% of the time?

   Answer: Nothing in the rule prohibits that. Best clinical practice should prevail.

95. Will we be cited in an audit if a person is in PSR too long?

   Answer: The mental health assessment needs to support the services on the treatment plan, and the ITP should address a transition plan to other services. You may be cited for these issues.

96. How does an agency provide Community Support to nursing home residents?

   Answer: DMH anticipates that most PSR services will include consumers who live independently in the community or with family. These consumers most certainly should have a CS service. This meets the Rule requirement that CS is provided in addition to the PSR service. In addition, agencies should begin to identify nursing home consumers who wish to or anticipate a return to living in the community and these should also have a CS service. For any consumer, including those living in nursing homes, even one to two hours per month in community support service meets the intention of the integration of PSR with Community Support.

97. 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.

98. 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.

99. 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.

100. Please clarify time on PSR schedule for individual time? How does this affect the schedule when a person is pulled out of group for individual time?

   Answer: We do not anticipate that a person would be pulled from group to participate in individual PSR. The intention is to provide some scheduled PSR service time that allows staff to meet individually with a consumer to work on individual skills, provide coaching on a skill, etc. The specific individual times/or "open time" should be reflected on the schedule and consumers should be clear as to how they can access individual time with a staff member. This open time is limited to five of the twenty five hours. The PSR schedule does not have to include individual/open time, as long as the twenty five hour requirement is met. No client is required to participate in 25 hours of PSR per week.

101. If two groups are running simultaneously, does that count as two hours of PSR service?

   Answer: No.

102. Is therapy/counseling counted as part of PSR service?

   Answer: No, therapy/counseling should be billed as therapy/counseling (see Reimbursement Guide). It is not part of the PSR twenty five hours schedule.

103. Our agency provides a lot of socialization activities. Can these be incorporated into the twenty-five hour PSR schedule?
Answer: No, the twenty-five hours on the PSR schedule should be hours of billable service. There are many socialization activities that DMH will not pay for. Remember, one of the original intentions of PSR was to provide community practice of skills in community settings, but was never intended for agencies to do this in very large groups. DMH does support the structured activities that meet CSI & CSG community practice.

104. We currently have a service funded thru DRS and DASA such as Supported employment. Are these services part of the PSR schedule?

Answer: All services that count for the twenty-five hours on the PSR schedule must meet the criteria defined in Rule 132 under the PSR service. A provider may have anything they like on the schedule, however the only things that count for the twenty-five hours of PSR are activities that meet the definition and are billable as PSR. Services already funded by another division or department cannot be submitted additionally for payment as a 132 service.

105. Regarding the twenty-five hour service requirement, if three groups are conducted simultaneously during the same hour (say 9:00 - 10:00 a.m.) does this count as three hours or as one hour?

Answer: This counts as one hour.

106. Can client-led groups count toward the twenty-five hours?

Answer: The definition of the twenty-five hours is that the twenty-five hours of PSR service has to meet the PSR service definition and be billable. This means the activity must be provided by qualified paid staff, who may also be consumers.

107. Are dual-diagnosis groups that are counted as counseling part of the twenty-five hour PSR schedule?

Answer: If the activity is being billed as counseling, it is not a PSR service.

108. Can the 25 hours include lunch time?

Answer: Lunch time is not a billable service. We recommend avoiding billing at this time, however, if specific staff are scheduled (assigned and available) at this time to provide a service to consumers and interaction between staff and consumers is focused on skills building, it may be billable.

109. If the state allows up to five hours of PSR individual time, can this be time when staff assist consumers with their manners at lunch?

Answer: If the focus is skills training, identified as an assessed need and is on the treatment plan, it may be billable.

110. Do MISA services have to be provided in PSR or can they be provided in the agency (referral to separate MISA group)?

Answer: The Rule requires a co-occurring capable staff as part of PSR staff. The intent is so that integrated substance abuse services can be provided and integrated into all PSR services.

111. How do you represent forty hours of programming when some sessions may be running concurrently?

Answer: The Rule requires twenty-five hours per week of available PSR services.

112. 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.
113. What does "a QMHP needs to be accessible" mean, i.e., by phone, on-site?

   Answer: When the QMHP is not on-site in the PSR program, being accessible means being available by telephone or designating an alternate QMHP to be available in person or by telephone.

114. Why does a CS-Team (higher acuity) prefer to have one person be an "individual in recovery", whereas PSR services now require a person "trained in & preferably certified in recovery"?

   Answer: The rule does not require that a PSR staff person be trained in and preferably certified in recovery. The rule requires that one member of the PSR staff be a person with experience, training or certification in co-occurring disorders. This reflects the department's desired direction for services.

115. 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.

116. 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.

117. The five hours of PSR individual time is not in the Rule, will this be reviewed by BALC (per client)?

   Answer: The five hours PSR individual is not a requirement per client. BALC will review the PSR schedule for twenty five hours of service that may include five hours of individual PSR time. If you are counting the five hours of individual time toward the twenty five hour requirement, we would expect to see times on the schedule that are available when PSR individual can be provided and/or accessed by consumers. This clarification provides flexibility on a twenty five hour service schedule to include time that is open and available for individual clients to either meet with staff individually or schedule a time for individual help with skill development.

118. Does the co-occurring capable MISA staff have to be through a formal MISA certification?

   Answer: There are no specific certification requirements for the co-occurring capable PSR staff. Specific documented training in the treatment of co-occurring disorders (MI and SA) provided internally at the agency meets this requirement as would other documented training or experience.

119. Regarding PSR staff ratios, can we include Administrative staff?

   Answer: No, unless administrative staff are providing direct service. PSR ratio applies to PSR groups.

120. Can we bill for PSR services provided to clients from a local long term care facility?

   Answer: PSR is an on-site only service. Therefore, it cannot be billed off-site. (5/31/11)

121. We’re in the process of hiring a new PSR staff person and want to make sure we hire someone with the right qualifications. The rule requires that at least PSR staff person have documented experience or training to provide services and interventions to clients with co-occurring psychiatric and substance abuse disorders. What type of experience would suffice?
Answer: The rule, and DMH, do not required certification, but expect that the provider will document whatever experience and/or training the staff person hired has that they believe qualifies them to provide services related to co-occurring disorders of MI and SA. Any such experience or training is acceptable at this time. (12/1/11)