

[PSYCHOSOCIAL REHABILITATION \(pdf\)](#)

1. 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.

2. 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.

3. 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 certified under Rule 132 and have 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.

4. 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.

5. 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. Community support should also be provided to the consumer to facilitate their learning to apply the skills learned in PSR to the community, thus facilitating their possible move to the community. The provision of services must be documented according to Rule 132 requirements.

6. 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.

7. 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.

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

Answer: Rule 132.150(i) 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.

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

Answer: Yes.

10. 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.

11. 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.

12. According to Rule 132, "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.

13. 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: The state will not pay for a PSR group to watch a movie or read a book. It will pay for the discussion directed toward individuals' goals, but not the reading or movie time.

14. 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.

15. 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. However, PSR is intended to assist clients' in gaining the 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."

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

Answer: Yes.

17. 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 Rule 132, another Q must be designated as the fill-in.

18. Can a consumer stay in PSR longer if they want?

Answer: It depends on the assessment of the person's needs. Rule 132 services may only be billed if medically necessary.

19. Does a consumer have to receive CS before getting PSR?

Answer: No.

20. 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.

21. 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.

22. 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.

23. 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.

24. 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.

25. 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.

26. 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.

27. 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.

28. 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.

29. 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.

30. 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.

31. 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.

32. 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.

33. 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.

34. 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.

35. 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.

36. 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, or when it does not relate to his/her mental health needs, is not billable.

37. 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.

38. 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.

39. If PSR compliments CS, what do we do with outpatients who receive only doctor/nurse/therapy but drops-in 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. It would be rare that a Rule 132 eligible client would not qualify to Community Support.

40. 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: How does this constitute 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. To be billable, there must be a direct intervention provided by staff related to a mental health need and included on the ITP. A client watching their diet and losing weight is not billable.

41. 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 during which the consumer practices the skills learned in PSR.

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

Answer: A consumer may receive 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 again could receive PSR for a time limited period to gain those capacities. During other periods of time, they could receive other 132 services as medically necessary.

43. 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.

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

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

45. 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.

46. Can you combine PSR & CS services?

Answer: The PSR model requires that a program offering PSR must also provide CS services. They cannot be combined into one service.

47. 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 and the 132 service provided must always be for treatment of the mental illness.

48. 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.

49. 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.

50. 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 certification. Clients who received CST must be authorized prior to the delivery of this service.

51. 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, and clients receiving CS are not required to also receive PSR. However, PSR must include CS.

52. 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?

53. **Answer:** Yes.

54. 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 provided by a staff with 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.

55. If a consumer is hospitalized for psychosis and upon discharge from the hospital, 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.

56. Can PSR providers bill other Rule 132 services if certified to provide them?

Answer: Yes.

57. 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 to specific clients may be billed and those periods of time must be at least 7.5 minutes each.

58. Must all PSR services be curriculum-based with documentation, including what curriculum was used and what portion/lesson was covered?

Answer: No.

59. 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.

60. 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. In fact, consumers should be receiving PSR and Community support. In CS, the consumers learn to apply the skills learned in PSR to their natural setting. Consumers cannot receive both ACT and PSR except during authorized periods of transition to or from ACT.

61. 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.

62. Can PSR be done off-site?

Answer: No.

63. 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).

64. 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 actual services provided to a client. It does not include rest periods or meals. Additionally, each staff person must bill for the unit of service they directly provide.

65. 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.

66. 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.

67. 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 as medically necessary, and the ITP should address a transition plan to other services. You may be cited for these issues.

68. Can a person involved in the PSR service also receive CSG?

Answer: Yes, that is a community support service (either CSG or CSI) that should be provided in conjunction with PSR.

69. 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 requirements. 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.

70. 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. The PSR schedule does not have to include individual/open time. No client is required to participate in any amount of PSR per week.

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

Answer: No, therapy/counseling should be billed as therapy/counseling (see Reimbursement Guide).

72. 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. Playing games is not billable.

73. 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.

74. 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.

75. 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.

76. 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.

77. 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. However, if clients who reside in the LTC facility come to your agency for PSR specific to needs assessed in a mental health assessment and indicated on an ITP and then have an opportunity to practice skills learned in community support, yes, you may provide PSR to them. (5/31/11)

78. 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 PSR staff 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 require 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)

79. Our agency provides PSR services and a question has been raised regarding the inclusion of PSR services in the objectives of the ITP. At this time, there are 16 groups offered as part of PSR. Is it required to name and describe each individual group and its purpose in the ITP or is it acceptable to just include PSR as a service to address an objective on the ITP?

Answer: The ITP must indicate the Rule 132 service to be provided to meet the objective listed. PSR is the service that must be listed. However, it will be important in the documentation of the delivery of PSR why a particular group is being used. For example, if the objective is to improve the client's ability to independently manage her finances, and the PSR group in which she is participating is to improve her ability in food preparation, those would not connect. Just because an objective has PSR listed as a service, the provision of the specific PSR group must relate to the objective and be medically necessary.

80. I understand that summary notes are not acceptable. I supervise a PSR program and we do daily summary notes. Is this acceptable?

Answer: No. (9/1/12)

81. Can we do one note per day for each PSR participant, but with a detailed description of the participant response in each PSR group?

Answer: Each PSR group is a discrete service. Each discrete 132 service must be documented separately. There must be a purpose related to the goals/objectives in the client's ITP for participation in each group. Therefore, each group must be documented for each person relative to their goals/objectives and the interactions that took place in that particular group. This must be documented by the staff person that led the group. (9/1/12)

82. For PSR services, may we document with one note per day per client?

Answer: You must document each incident of PSR service. PSR is not a daily service and daily notes are not allowable. (9/1/13)