

Psychosocial Rehabilitation Medical Necessity Criteria

Program Description

Psychosocial Rehabilitation (PSR) is a community-based program that promotes recovery, community integration, and improved quality of life for members who have been diagnosed with a behavioral health condition that significantly impairs their ability to lead meaningful lives. The goal of Psychosocial Rehabilitation is to restore the fullest possible integration of the member as an active and productive member in their family and/or community, with the least amount of professional intervention. Psychosocial Rehabilitation program services support members in developing emotional, social, intellectual, and independent living skills necessary to live learn and work as active, healthy and productive members in their communities through interventions developed by behavioral health professionals or certified peer recovery specialists in partnership with the member. Psychosocial Rehabilitation interventions are face-to-face, collaborative, and person-centered and may be provided individually or in a group setting.

Psychosocial Rehabilitation program services involve actively engaging the member in services, which includes individualized service plan goals aimed at achievable and measurable outcomes in the areas of education, vocation, recreation and social support, as well as developing structure and skills training related to activities of daily living. Psychosocial Rehabilitation interventions focus on the member's strengths, needs, abilities, and preferences rather than treatment for symptoms of mental illness. Psychosocial Rehabilitation must meet medical necessity based on criteria cited in the TennCare Rules and may be provided in conjunction with routine behavioral health outpatient services.

Psychosocial Rehabilitation program services vary in intensity, frequency, and duration in order to assist the member in maximizing their functional capabilities.

Admission Criteria

Psychosocial Rehabilitation program services must meet medical necessity based on criteria cited in the TennCare Rules 1200-13-16-.05, including the recommendation from a licensed physician who is treating the member or other licensed healthcare provider practicing within the scope of his or her license who is treating the member or is part of the treatment team.

AND

1. The member has a severe and persistent mental health condition that meets diagnostic criteria, and has significant difficulty to consistently and independently manage and utilize activities of daily living or obtaining community resources, and requires assistance in one or more areas related to the following activities of daily living domains:

- a. Personal finance

- b. Healthcare and personal hygiene
- c. Nutrition and meal preparation
- d. Home maintenance
- e. Employment or education
- f. Childcare
- g. Legal, housing, transportation, and other community service needs
- h. Maintaining social and/or family relationships

And all of the following:

- a. The member is not in imminent or current risk of harm to self/others and/or property
- b. The member is capable of actively engaging in the program in an ambulatory setting, or consents to participate in the program with support from the psychosocial rehabilitation program's staff in a reasonable amount of time
- c. Less intensive services would not be adequate to assist the member in reaching identified treatment goals
- d. Psychosocial Rehabilitation Services are for diagnosis or treatment of the particular medical condition in accordance with TennCare Rules 1200-13-16-.01

Program Service Expectations

1. An individualized service plan shall be completed within 14 calendar days of the start date of service and reviewed within three (3) months of the initial development. Subsequent reviews/updates shall occur every six (6) months, or more frequently as clinically appropriate. Service plan reviews/updates need to reflect progress or status of objectives on the plan. A Tennessee licensed mental health professional is either on staff or available on a consultative basis to review and sign the individualized service plans.
2. The service plan shall be developed, negotiated and agreed upon by the member and/or their natural support systems in face-to-face encounters and shall be used to identify the intervention needs necessary to meet the member's stated goals. The duration and intensity of the intervention shall promote the recovery of the member and shall be documented in the service plan. Documentation of the member's service plan must be made in the member's record and shall include, but is not limited to, the following:
 - a. Needs and strengths of the member that are to be addressed within the particular PSR service/program component
 - b. Clear indication of the service modality including the team member responsible for monitoring progress of the services delivered
 - c. Short-term and long-term recovery goals that are individualized, achievable, and measurable
 - d. Evidence-based approaches and interventions* used to support the member in achieving his/her recovery goals, focusing on the following:
 - i. Utilization and enhancement of strengths
 - ii. Illness management
 - iii. Activities of daily living

- iv. Daily structure including supported employment and/or education-related activities
- v. Family and social relationships and how they will participate in the program as clinically indicated
- vi. Identification of specific interventions to address barriers impeding attainment of recovery goals
- vii. Increased community engagement aimed at providing new and ongoing social, educational, cultural and vocational experiences to help restore or strengthen the member's connection to his/her community

***Materials supporting evidence-based approaches and interventions shall be made available upon the MCO's request.**

3. The individual record for each member shall contain the following information:
 - a. An individualized service plan and all applicable updates
 - b. Record of daily attendance and participation at program services
 - c. When appropriate, a discharge summary that describes the member's condition at the time of discharge and signature of PSR staff preparing the discharge summary
 - d. Written documentation of the member's progress and changes which have occurred within the service plan. At a minimum, weekly summary progress notes shall be developed to include all of the following:
 - i. Location of the intervention/service (e.g., community or office)
 - ii. Date, start time, and duration of the intervention/service
 - iii. The goal of the intervention/service, which must coincide with the current service plan goals
 - iv. Summary of each intervention/service and the member's progress and/or response to the intervention/service
 - v. Progress notes must be dated and minimally include the signature, with title or degree, of the person preparing the note
 - vi. Referrals to community-based services and peer support services, as appropriate
 - vii. Documentation of coordination of PSR program services with other providers
4. Within Fourteen (14) calendar days of the start date of service the following occurs:
 - a. Initiate contact with providers who were involved with the member's treatment prior to admission to obtain information about the member's condition and response to the program, with the member's documented consent
 - b. Agencies and programs, such as the school or court system, with which the member has been involved, are contacted, with the member's documented consent, to coordinate services when appropriate
5. At a minimum, the provider and the member collaborate to formally review the service plan as clinically appropriate. These reviews should include, but are not limited to, a well-documented clinical rationale for continuation of services, updated goals and progress made in the program, and

demonstration of members engagement in the program. However, revisions to the service plan should be made at any time whenever there are significant changes in the member's condition, diagnosis, preferences, and/or needs.

Continued Stay Criteria includes all of the following: **6-9 or 10** are present:

6. The member continues to meet admission criteria as determined by a licensed physician who is treating the member or other licensed healthcare provider practicing within the scope of his or her license who is treating the member or is part of the treatment team;

AND

7. Documentation of member's participation and engagement in services

AND

8. Documentation of at least a moderate degree of functional impairment, in a minimum of one activities of daily living domain, is still present and related to the most current DSM/ICD diagnosis and is likely to improve with continued PSR interventions

AND

9. Movement towards recovery-based goals is documented as evidenced by adherence with the program, improvement of functional impairment, and continued progress is expected for the targeted skills with the specific goals being implemented

OR

10. If progress is NOT documented, either diagnosis has been re-evaluated and changed if appropriate, medication has been re-evaluated and changed if indicated, or PSR and the intervention approach has been re-evaluated and changed if appropriate to include new goals/targets.

Exclusion Criteria

11. Psychosocial Rehabilitation program services (PSR) are considered not medically necessary when the Continued Stay criteria are not met

OR

12. The member refuses service

Discharge Criteria:

13. A discharge plan is developed when any of the following occur:

- a. The provider and the member agree that the member has achieved his/her short- and long- term goals

- b. The member is going to move outside of the geographic area served by the psychosocial rehabilitation program
 - i. In the event of relocation or premature discharge, the provider will work with the member to gain access to other appropriate services
 - ii. The provider will maintain contact with the member until the member has accessed other services
 - c. The member requests discharge despite the provider's recommendation that services be continued. In such cases, recommendations as to what the member should do in the event of a crisis should be included in the discharge plan
 - d. In absence of discharge criteria (a), (b) and (c) above, the member continues to demonstrate lack of progress or lack of benefit from PSR program services.
14. The member and/or their natural support systems shall be involved in the development of the discharge plan in face-to-face encounters