PROS Redesign Provider Frequently Asked Questions

This document is intended to answer frequently asked questions regarding PROS Redesign. The Office of Mental Health (OMH) will revise and reissue this document as needed. Additional questions can be sent the PROS Mailbox.

Table of Contents

Section 1: Implementation 2
Section 2: Components and Services 3
Section 3: Staffing 3
Section 4: Documentation 4
Section 5: Service Delivery & Operations 7
Section 6: Reporting Requirements 7
Section 7: Billing 7

Acronym Key: The below acronyms are commonly used throughout this document.

CCM	Complex Care Management
CRS	Community Rehabilitation and Support
CT	Clinical Treatment
EHR	Electronic Health Record
IR	Intensive Rehabilitation
IRP	Individual Recovery Plan
ISR	Initial Service Recommendation
LPHA	Licensed Practitioner of the Healing Arts
MCTAC	Managed Care Technical Assistance Center
ORS	Ongoing Rehabilitation and Support
SOC	Standards of Care

Section 1: Implementation

Issued	#	Question	Answer
8/7/2024, Updated 1/6/2025	1	What is the go-live or implementation date for PROS redesign?	We are anticipating a Spring 2025 “go-live” date. Providers and Managed Care Organizations will be given 90-days’ notice prior to implementation.
8/7/2024	2	Will PROS programs need to update their Electronic Health Records (EHRs) and Electronic Billing Systems (EBSs) in advance of the redesign go-live date?	Upon the implementation of PROS redesign, programs will need to meet new regulatory requirements and guidance related to documentation and billing/claiming. Updating your EHR/EBS is the best way to ensure your program is meeting all requirements. However, if the changes to your systems will take more time, we encourage you to contact your local field office or the PROS mailbox for technical assistance, as your program may need to monitor compliance with documentation requirements or submit claims manually pending system updates.
8/7/2024	3	With the revised documentation requirements, will PROS programs get any financial support in implementing these changes in our EHR? Will we receive templates for documentation requirements?	OMH has recently distributed American Rescue Plan Act (ARPA) funding, which may be used for costs associated with PROS Redesign changes. In addition, we encourage all agencies to check their vendor contracts, as some may have a clause to support updates due to regulatory and guidance changes. At this time, OMH does not anticipate developing documentation templates or forms. Additionally, MCTAC will be working with vendors to support the updates needed to provider EHRs.
8/7/2024	4	Will PROS Standards of Care (SOC) be updated as part of redesign?	Yes, the PROS SOC will be updated to align with the amended Part 512 regulations.

Section 2: Components and Services

Issued	#	Question	Answer
8/7/2024	1	Where can ORS Services be provided?	ORS must be provided off-site or via telehealth, if the program has been approved to provide telehealth and the participant has been assessed as appropriate for telehealth. ORS may not be provided on-site at the PROS program. Locations owned by the agency but not at the same address as the PROS program may be used for ORS services.
8/7/2024	2	Can someone that is enrolled in Health Home Care Management receive CRS – Complex Care Management (CCM)?	Yes. CRS – CCM is a *non-routine* rehabilitative service designed to coordinate care due to an urgent need. If a participant has a Health Home Care Manager, we encourage the PROS program to work closely with the HHCM related to any ongoing or routine care coordination needs. The Operations Manual includes several examples of when CCM may be appropriate to prevent the loss of a life role and to maintain community tenure.
8/7/2024	3	With PROS redesign, are there any changes to rules for telehealth?	There have been no changes made to Telehealth regulations or guidance. PROS programs should continue to refer to the Telehealth Services Guidance for OMH Providers.
1/6/2025	4	How long can a participant receive the Complex Care Management service?	CCM is a non-routine rehabilitative service designed to coordinate care due to an urgent need. OMH has not established a time limit on this service. However, if a participant has ongoing care coordination needs, they should be referred to a care management service such as Health Home.

Section 3: Staffing

Issued	#	Question	Answer
8/7/2024	1	For PROS with Clinic Treatment, is it possible to replace a RN with an LPN?	It may be possible for a program to meet individuals' nursing needs by replacing the RN with an LPN. However, there are considerations including the added work that would be required by the psychiatric provider (NPP or MD). The LPN must work within their scope of practice as defined by the New York State Education Departments Office of Profession. For example, LPNs do not have it within their scope of practice to formulate an assessment on the health data that they collected, meaning the supervising NPP or MD would need to participate in the Health Assessment process.
8/7/2024	2	Is there a recommendation for caseload sizes per staff member?	OMH has not established recommendations for caseload sizes. The overall PROS program must have a minimum staffing ratio of 1:14, but not all Team members are required to carry a caseload and caseload sizes may vary between team members based on a variety of factors.
1/6/2025	3	How are Mental Health Counselors classified under PROS staffing qualifications?	A Licensed mental Health Counselor would be considered both a Professional Staff and an LPHA (Licensed Practitioner of the Healing Arts).

1/6/2025	4	How are MSW Limited Permit Holders (MSW-LP) classified under PROS staffing qualifications?	An MSW with a limited permit to practice would be considered a Professional staff but would not meet the qualifications for an LPHA.
1/6/2025	5	If our program currently employs an uncertified peer, do they have to get certified to continue working in PROS?	No. Peers lacking certification may be paraprofessional or professional staff based on their credentials, training, and experience. They may continue providing any PROS services based on such qualifications. Only team members delivering CRS – Peer Support Services require peer certification/credentialing.
1/6/2025	6	Is there a maximum caseload size for the IPS Employment Specialist?	No. OMH has not established a maximum caseload size for the IPS Employment Specialist. However, in keeping with the IPS model, PROS programs should endeavor to ensure that caseloads do not exceed 1:20 on a regular basis.
1/6/2025	7	Which staff need to complete the required trainings?	PROS Team Members who provide direct services to participants, and their supervisors, must complete required trainings as described in the PROS Staff Training & Competencies Guidance. This does not include administrative staff who are not involved in service delivery or direct supervision.
1/6/2025	8	If our program employs multiple LPHAs, do they all count toward the Professional Staff ratio?	Yes. All LPHAs are Professional Staff, and all LPHAs count toward the Professional Staff ratio (1:34).

Section 4: Documentation

Issued	#	Question	Answer
8/7/2024	1	Will OMH provide the screening tools or measures for Screening for Risk of Harm to Self and Others or Alcohol, Tobacco, and other Drug Assessment?	OMH has not required or established specific screening tools. Programs will continue to have discretion to select appropriate evidence-based assessment/screening tools.
8/7/2024	2	Will programs need to complete psychosocial assessments for individuals admitted after redesign?	No, the requirement for the psychosocial assessment has been removed. Programs may choose to complete the psychosocial assessment, formally or informally, as part of their individualized recovery planning process.
8/7/2024	3	Will IRPs need to be written anew when the redesign goes into effect? Will there be a transition period during which the new IRPs can be completed?	IRPs may be fully updated when the next review is due, but all IRPs must be in compliance with signature requirements on the redesign implementation date. This means that if an LPHA has not approved and signed the current IRP, this must be done on or before the redesign implementation date. The IRP for any new participants admitted on or after implementation must meet the new requirements outlined in guidance and regulations.

8/7/2024	4	Has the Relapse Prevention Plan requirement in the Individual Recovery Plan (IRP) been removed or was it completely taken out as a documentation requirement?	The Relapse Prevention Plan is no longer a requirement and instead has been replaced with the Personal Wellness Plan, which is optional and does not need to be a part of the IRP.
8/7/2024	5	Are there any services that we can be provided without being identified on the IRP or ISR?	PROS programs may provide services that were not included on the IRP, often in response to an urgent situation or crisis. The staff who provides the services should clearly describe the need for the service or rationale for providing it in the narrative of a progress note. If the service is one which requires supervision by a Professional Staff or LPHA, the qualified supervisor must be involved in making the decision to provide the service. If the service is or will be needed on a regular and routine basis, it must be approved by an LPHA and added to the IRP.
1/6/2025	6	Please clarify which IRP signatures are needed for the IRP to be considered complete.	An IRP is considered completed when the staff who developed the IRP and the LPHA have signed it.
1/6/2025	7	If required assessments are started during pre-admission, when are they due?	Required assessments must be completed within 60 days of admission and prior to the development of the initial IRP. For example, if an individual begins pre-admission on July 1st and the program begins the Comprehensive Psychiatric Rehabilitation Assessment on July 5th, and then the individual is enrolled on August 1st, the Comprehensive Psychiatric Rehabilitation Assessment needs to be completed by September 30th (60 days from August 1st) or prior to the development of the initial IRP, whichever is sooner.
1/6/2025	8	What services need to be listed on the IRP?	Any service provided on a regular and routine basis must be included on the IRP. See pg. 60 of the Operations Manual for details on how to document services provided on an urgent/emergent basis which are not included on the IRP.
1/6/2025	9	Does the IRP need to include specific group or class names?	No. The IRP must include the specific PROS Services to be provided, including type and frequency. For example, instead of listing a cooking group, a relationship skills group, and a stress management group individually, the IRP might reflect CRS – Psychosocial Rehabilitation with the total expected frequency. The minimum required elements for an IRP are outlined on pg. 57 of the Operations Manual.
1/6/2025	10	Given that there is no longer the need to count or document Program Participation Time, can we still utilize attendance sheets?	Yes.

1/6/2025	11	Can group attendance sheets be used in place of group notes (documentation of group-based service delivery)?	Yes, if the attendance sheet includes all the required elements outlined on pg. 61 of the Operations Manual.
1/6/2025	12	Do start and end times need to be indicated in group notes (documentation of group-based service delivery)?	Yes, the documentation for each group or class must include start and end times for each participant attending the group or class.
1/6/2025	13	How should we document the location for off-site service delivery?	The service location is required for group-based and individual services. Because OMH has not established a required template for documentation of service delivery, programs have different options for how they might meet this requirement. For off-site groups, if a checkbox or dropdown box is used, the narrative of the note should indicate additional details regarding where the service took place. This does not need to be a street address but should accurately describe where services were provided. For example, “Individual’s Home,” “Central Park,” “at an MTA station and on the subway.”
1/6/2025	14	Do assessment services (i.e., Psychiatric Rehabilitation Assessment) need to be included on the IRP?	Assessment services would not typically be included on an IRP unless the service will be provided on a regular basis. For example, a participant may meet with a member of the PROS Team for weekly 1:1 sessions focused on setting a psychiatric rehabilitation goal, using the CRS – Psychiatric Rehabilitation Assessment service to assess their readiness, explore personal beliefs, identify critical skills and supports, etc. In this example, the CRS – PRA service *should* be included on the IRP because it is a planned part of their participation in PROS. If an assessment is needed but will not be provided on a regular and routine basis, the need for the assessment service, or rationale for providing it, would be documented in the narrative of the progress note (documentation of service delivery). See pg. 60 of the Operations Manual for more information.
1/6/2025	15	When an assessment is updated, would that be documented and billed as a CRS – Individualized Recovery Planning service or as the specific assessment service (i.e., CRS – Psychiatric Rehabilitation Assessment)?	Assessments may be updated in different ways. If a significant or complete update or re-assessment is needed, the assessment should be documented and billed under the appropriate service category based on the assessment service provided. If an assessment is updated based on new information discovered through the Individualized Recovery Planning process, and that information does not result in the need for a full re-assessment, it would be appropriate to document and bill this as an Individualized Recovery Planning service.

Section 5: Service Delivery & Operations

Issued	#	Question	Answer
1/6/2025	1	Do participants need to see the Psychiatrist or Nurse Practitioner in Psychiatry (NPP) if they are not prescribed medication at the PROS?	Participants who are enrolled in Clinical Treatment at PROS must receive the Psychiatric Assessment within 60 days of enrollment in the CT component and before the development of their initial IRP. This assessment may only be completed by a psychiatrist or NPP. If the participant will not be receiving the Medication Management service through PROS (e.g., they are only receiving Clinical Treatment and Counseling), they do not need to see the Psychiatrist or NPP on an ongoing basis after the initial assessment.
1/6/2025	2	Can you give examples of appropriate off-site locations?	Off-site locations should be chosen based on the needs and preferences of the participant and related to their goal, objectives, and needs. Off-site locations could include but are not limited to the individual's home or workplace, local parks or community centers, grocery stores, the post office, a community college, etc.

Section 6: Reporting Requirements

Issued	#	Question	Answer
1/6/2025	1	Is registration in the Child and Adult Integrated Reporting System (CAIRS) still required?	Yes. However, the Recipient Attestation form is no longer required.
1/6/2025	2	When are CAIRS follow-ups due?	CAIRS follow-up reporting is due every 6 months for the participant's full length of stay in PROS.

Section 7: Billing

Issued	#	Question	Answer
1/6/2025	1	Please clarify the minimum threshold to bill for the monthly base rate.	The minimum threshold to bill for the monthly base rate (Rate Code 4516) is 4 units of CRS. Programs may not submit a monthly base rate claim if the only CRS service provided is Complex Care Management. For more information see pgs. 12-13 of the PROS Billing & Claiming Manual.
1/6/2025	2	Can the units accrued from services delivered off-site be counted toward the minimum threshold for the monthly base rate?	Yes, units accrued off-site may be counted toward the minimum threshold for the monthly base rate. However, only unadjusted units will count, meaning that an individual would need to receive a minimum of 4 units of CRS (adjusted to 8 units) in order to meet this threshold. If an individual only accrues 2 unadjusted units of CRS off-site (adjusted to 4 units), this would *not* meet the minimum threshold for the monthly base rate.

1/6/2025	3	Will providers be reimbursed for ORS + Clinic Treatment without the monthly base rate?	No. The Monthly Base Rate is required in order to be reimbursed for the CT Add-On.
1/6/2025	4	Can programs bill for more than 5 units per day?	A maximum of five unadjusted PROS Service Units may be counted per day. To recognize the higher costs associated with provision of services delivered outside of the PROS site, in the community, PROS Service Units provided off-site will be doubled. This adjustment allows for up to five PROS service units to be doubled to ten per day. For more information see pgs. 12-13 of the PROS Billing & Claiming Manual.
1/6/2025	5	If participant attends two (2) 45-minute groups in one day, is that 2 units or 3 units?	In this example, it would be two (2) units. For group-based services, a PROS unit is defined as 30 continuous minutes. There are no partial units, and because the individual's total *time* in groups (90 minutes) is not continuous, the total units accrued would be 2 units. However, if a participant attends a single 90-minute group, this would accrue 3 units.
1/6/2025	6	Are there any differences in the documentation and signature requirements in order to bill Medicare for Clinical Treatment services?	There are no specific treatment planning requirements for community-based PROS services covered by Medicare Part B. For hospital-based PROS providers, evidence of a physician established treatment plan for any psychiatric services billed is required to by both Medicare and Medicaid.