

Outpatient Family Psychotherapy – Child Adolescent MH

Definition

Outpatient family psychotherapy is a therapeutic encounter between the licensed treatment professional, the youth, and the nuclear family that includes at least one parent/caregiver. The parent/caregiver must be an adult identified as having a current and long-term future commitment with the youth (e.g., guardian, foster parents, extended family with an established relationship and long term future commitment). The specific objective of treatment must be to increase the functional level of the family in support of the identified client's MH/SA active diagnostic symptoms. This therapeutic intervention must be provided with the identified client and family members present. (See "Family Therapy Without Member Present" for alternative special procedures).

*Therapists of youth with more than one mental health/substance abuse provider must communicate with and document coordinated services with any other mental health/substance provider for the family or individual family members. Documented coordination of services is required as part of the overall treatment plan and is not billable as a separate Medicaid service. Documentation must describe the coordination of all services in the treatment record, and reviews by the supervising practitioner.

Policy

Outpatient mental health services are available to youth aged 20 and younger.

Magellan Behavioral Health will authorize outpatient family psychotherapy services based upon the following guidelines:

- One family psychotherapy session on any particular day per family
- Authorize for the procedure code 90846 (family psychotherapy without the client present) only by exception (See Special Procedures).
- Authorize one family psychotherapy session for families even though the family may have multiple Medicaid eligible members with a psychiatric and/or substance abuse diagnosis. Only one Medicaid eligible family member may be billed for family psychotherapy even though another identified Medicaid eligible member may be present in the family psychotherapy session.

Program Requirements

Refer to the program standards common to all levels of care for general requirements.

The agency must have written policies and procedures related to:

Refer to the "Standards Common to all Levels of Care" for a potential list of policies generally related to the provision of mental health and substance abuse treatment. Agencies must develop policies to guide the provision of any service in which they engage clients, and to guide their overall administrative function.

Features/Hours

The Outpatient family psychotherapy services must be provided in a confidential setting such as an office, clinic, the youth's home, or other professional service environment. The service must be available during times that meet the need of the youth and their family to

include after school, evenings, and weekends. Scheduled, routine psychotherapy services should not interfere with the youth's academic and extracurricular schedule. The service provider must assure that the youth, and parent/caregiver has on-call access to a mental health provider on a 24-hour, seven-day per week basis.

Service Expectations

Family psychotherapy services must:

- Be medically necessary
- Address issues related to the functioning of the entire family unit.
- Be youth centered and family focused with goals and objectives that are clearly stated in the youth's individualized treatment plan
- A comprehensive bio-psychosocial assessment which must include a comprehensive family assessment must be completed prior to the beginning of treatment, or if previously completed, the provider should obtain and review this assessment in lieu of completing a new assessment. If upon review the assessment is no longer clinically current, the provider will update the assessment.
- The initial diagnostic interview must be conducted for the youth (identified client) by a psychiatrist, psychologist, or licensed independent mental health practitioner (LIMHP) prior to the beginning of treatment
- Assessment should be ongoing with treatment and used to inform and establish time-limited and measurable, symptom focused treatment goals and objectives.
- Treatment interventions should be based on the comprehensive assessment which includes a family assessment, and focused on specific treatment goals inclusive of the culture, expectations, and needs as identified by the youth and parent/caregiver.
- The family treatment/discharge plan is reviewed and updated by the youth, parent/caregiver and the supervising practitioner as frequently as medically indicated, but at a minimum of every 90 calendar days, and signed by all participants.
- Be developmentally appropriate for the youth (identified client)
- Consultation and/or referral for general medical, psychiatric, psychological, and psychopharmacology needs
- The therapist/licensed clinician must assist the youth and parent/caregiver in identification and utilization of community resources and natural supports which must be identified in the discharge plan.
- It is the provider's responsibility to consult with other treating professionals as necessary
- Family psychotherapy services must be a 60-minute session, at a minimum.

Staffing

Staff, licensed to practice in the State of Nebraska, enrolled with Nebraska Medicaid, contracted and credentialed with the managed care entity, and acting within their scope may provide this service and include:

Therapist:

- Licensed Mental Health Practitioner (LMHP)
- Provisionally Licensed Mental Health Practitioner (PLMHP)
- Licensed Independent Mental Health Practitioner (LIMHP)

- Licensed Psychologist
- Provisionally Licensed Psychologist
- Advanced Practice Registered Nurse (APRN) (if utilized must have a psychiatric specialty, and work in collaboration with a psychiatrist)
- Psychiatrist

Supervising Practitioner (individuals meeting the requirements of a supervising practitioner are not required to have additional supervision to provide the therapy service)

- Psychiatrist
- Licensed Clinical Psychologist
- Licensed Independent Mental Health Practitioner (LIMHP)

Supervising Practitioner Involvement

- Meet with the client face-to-face to complete the initial diagnostic interview
- Provide face-to-face service to the member at least annually or as often as medically necessary.
- Review the Biopsychosocial Assessment (Part I of the Pretreatment Assessment) if completed by another practitioner.
- Complete the Initial Diagnostic Interview (90801 Part II of the Pretreatment Assessment) which includes a summary of the chief complaint, a history of the mental health and/or substance abuse condition, a mental status exam, formulation of a diagnosis and the development of a plan.
- Provide the therapist an individualized narrative document (see Pre-Treatment Assessment for assessment format) that includes all of the components of the Initial Diagnostic Interview (90801). If treatment is deemed medically necessary, recommendations for a course of treatment are provided.
- Provide a supervisory contact with the provisionally licensed therapist every 30 days or more often as necessary and for the fully licensed therapist, every 90 days or more often as necessary. Direct face-to-face contact is preferred; however, communication may occur by telephone. Supervisory contact will include:
 - Review of the treatment recommendations developed in the Pretreatment Assessment (Biopsychosocial Assessment and Initial Diagnostic Interview) by the therapist and the Supervising Practitioner
 - Update on the status of the client, including progress achieved, barriers which impair movement in treatment, to include and critical incidents which involve safety to self or others such as aggression or self-harm. (The incident depending on severity may have been previously reported at the time of the incident.)
 - Review of the treatment/recovery plan and the progress notes provided by the therapist.
 - Determination of the plan for ongoing treatment, with any change in focus or direction of treatment.
 - Review of the discharge plan and the recommendation for changes in discharge as necessary.

- Changes in the discharge plan are documented in the client's clinical record.

Documentation

The therapist will maintain a complete clinical record of the family's treatment. The clinical record will contain the Pretreatment Assessment (which should include a detailed family assessment), the master treatment plan and treatment plan updates, family therapy progress notes that identify goals of the treatment and discharge plan, a complete record of supervisory contacts, narratives of other case management functions, case coordination, and other information as appropriate and relates to the family's treatment. All client records of service must be readily available in English. *Each progress note must include every family member involved in session, the date and start/end time of each family session.

Length of Stay

Length of service is individualized and based on clinical criteria for admission and continuing stay. Frequency and duration is expected to be adjusted based upon the symptoms and acuity of the mental health/substance abuse diagnoses for which they were admitted. As clients make progress toward treatment goals, frequency and duration of the service is expected to decrease. If progress is not being made and client stability is not increasing, the treatment plan must be adjusted to promote progress.

Special Procedures: See Clinical Guidelines: Outpatient Family Psychotherapy Without Member Present (below)

For client's who present with co-occurring mental health and substance abuse symptoms and diagnoses, the provider must refer to the Youth Criteria of the Patient Placement Criteria for the Treatment of Substance-Related Disorders of the American Society of Addiction Medicine, Second Edition Revised (ASAM PPC-2R or current version) pages 209-215. Providers are responsible to refer to the ASAM PPC-2R Youth Placement Manual for complete criteria. The provider must also adhere to the service descriptions and clinical guidelines for SA Outpatient Level I as well as the clinical guidelines identified in this service description.

Clinical Guidelines: Outpatient Family Psychotherapy – Child – Adolescent MH

Admission Guidelines:

All of the following Guidelines are necessary for admission to this level of care:

1. The child/adolescent demonstrates symptomatology consistent with a DSM (current edition) diagnosis which requires, and can reasonably be expected to respond to, the proposed psychotherapy intervention.
2. There are significant symptoms that currently interfere with the child/adolescent's ability to function in at least one life area.
3. There is an expectation that the child/adolescent has the developmental level and/or capacity to make significant progress toward treatment goals.

Exclusion Guidelines:

Any of the following guidelines are sufficient for exclusion from this level of care:

1. The patient must be present during all family psychotherapy sessions. Any meeting in which the patient is not present cannot be billed as Family Therapy under Medicaid guidelines.
2. The child/adolescent requires a level of structure and supervision beyond the scope of Outpatient Family Therapy.
3. The child/adolescent has a medical condition or impairment that warrants a medical/surgical setting for treatment.
4. The primary problem is social, educational, or economic (i.e. family conflict, need for a special school program, housing, etc.), one of physical health without concurrent major psychiatric episode meeting, or treatment is being used as an alternative to incarceration.
5. Treatment goals are educational or supportive in nature or are intended to address issues other than currently active symptoms of a DSM diagnosis causing significant functional impairments.
6. Treatment for Pervasive Developmental Disorders and/or adaptive limitations from Pervasive Development Disorders is ineligible for Medicaid reimbursement.

Continued Stay Guidelines:

All of the following Guidelines are necessary for continuing treatment at this level of care:

1. The child/adolescent's condition continues to meet Admission Guidelines for this level of care.
2. The child/adolescent's treatment continues to require the current level of care. A less intensive level of care would not be adequate for continued progress and a more intensive level of care does not appear to be necessary for continued progress to occur.
3. Treatment planning is individualized and appropriate to the child/adolescent's changing condition, with realistic and specific goals and objectives clearly stated and progress on each goal documented.
4. The treatment plan is carefully structured to achieve optimum results in the most time efficient manner possible, consistent with sound clinical practice.
5. Progress in relation to the DSM disorder symptoms is clearly evident and is described in objective terms.
6. Goals of treatment have not yet been fully achieved and adjustments in the treatment plan to address lack of progress are documented.
7. Care is rendered in a clinically appropriate manner and focused on the child/adolescent's objective functional outcomes as described in the treatment plan.
8. When appropriate, the child/adolescent is referred for psychopharmacological evaluation and intervention, and, when necessary, for re-evaluation. Collaboration with the prescriber should include regularly reporting information about side effects, compliance and effectiveness.
9. There is active discharge planning documented.

Discharge Guidelines

Any of the following Guidelines may be sufficient for discharge from this level of care:

1. The child/adolescent no longer meets Continued Stay Guidelines, or meets Guidelines for a less, or more, intensive level of care.
2. The child/adolescent's and/or family's documented treatment plan goals and objectives have been substantially met.

3. In spite of documented attempts to address non compliance, the child/adolescent and his or her family's attendance is at a level that renders continued outpatient family therapy ineffective.
4. Consent for treatment is withdrawn by the parent or legal guardian.

Clinical Guidelines: Outpatient Family Psychotherapy Without Member Present

(This service is offered only by exception: See Request for 90846, Family Therapy Without Member Present, Provider Handbook and Supplements, Appendix C)

Admission Guidelines:

1. Involve the individual's family with a therapist for the purpose of changing a behavior health/substance abuse condition focusing on the level of family functioning as a whole and address issues related to the entire family system. There is a ***clinical*** reason why the individual is not present for the session.
2. Family psychotherapy without member present is recommended by the PTA, CCAA or CFA as medically necessary to achieve goals/objectives for treatment of a behavior health/substance abuse condition.

Exclusionary Guidelines:

1. An encounter between a family member(s) and a licensed therapist in which the family member(s) briefs the therapist about the behaviors, symptoms and problems of the identified client
2. An encounter between a family member(s) and a licensed therapist in which the therapist briefs the family member(s) about the identified client's behaviors and problems, progress or barriers to progress
3. A supportive and/or educational discussion between family and a licensed therapist
4. A therapeutic encounter between a family member of the identified client and a licensed therapist in which the therapist provides psychotherapy to address the family member's individual treatment issues
5. A segment of an individual therapy session that is used by a licensed therapist or family member(s) to clarify therapy progress, prognosis, intervention success, homework completion, etc. of the identified client
6. Is focused on the mental health/substance abuse needs, goals or objectives of a family member that is not the primary client.
7. Treatment for Pervasive Developmental Disorders and/or adaptive limitations from Pervasive Development Disorders is ineligible for Medicaid reimbursement.

Continued Stay Guidelines:

1. ***All*** of the following Guidelines are necessary for continuing treatment at this level of care:
 1. The individual's condition continues to meet admission Guidelines at this level of care.
 2. The individual's treatment does not require a more intensive level of care.
 3. Treatment planning is individualized and appropriate to the family's changing condition, with realistic and specific goals and objectives clearly stated.
 4. All services and treatment are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice.

5. Progress in relation to specific dysfunction is clearly evident and can be described in objective terms, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address lack of progress are evident.
6. Care is rendered in a clinically appropriate manner and focused on the family's behavioral and functional outcomes as described in the discharge plan.
7. There is documented active discharge planning.

Discharge Guidelines

Any one of the following Guidelines is sufficient for discharge:

1. The individual's and/or the family's documented treatment plan goals and objectives have been substantially met.
2. The individual no longer meets admission Guidelines.
3. The focus of therapy is no longer on the family system.
4. Consent for treatment is withdrawn.

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