

Outpatient Group Psychotherapy – Child and Adolescent MH

Definition

Outpatient group psychotherapy is active treatment of a DSM (current version) psychiatric disorder through scheduled treatment interventions with a common goal in the context of a group setting. A group is described as at least three individual clients and no more than twelve clients facilitated by a licensed practitioner. The focus of outpatient group psychotherapy treatment is to improve the youth's ability to function as well as alleviate symptoms related to their diagnosis that may significantly interfere with their functioning. The goals, frequency, and duration of outpatient group treatment will vary according to individual needs and response to treatment.

***Groups that are primarily focused on providing education or support do not meet the definition of outpatient group psychotherapy for Medicaid and, as such, are not reimbursable.**

***Therapists of clients 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.**

Policy

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

Program Requirements

Refer to the program standards common to all levels of care for general requirements. All therapeutic groups must be approved by the managed care entity and Nebraska Medicaid prior to the admission of individuals for group therapy services.

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

Outpatient group psychotherapy services must be provided in a confidential setting such as an office, clinic, or other professional service environment. The service must be available, during times that meet the needs of the youth and their family to include after school, evenings, and weekends. Scheduled, routine group 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

- A comprehensive bio-psychosocial 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 by a psychiatrist, psychologist, or licensed independent mental health practitioner (LIMHP) prior to the beginning of treatment
- Typically group psychotherapy is expected to be provided as an adjunct intervention to individual and/or family therapy, and not as a stand-alone service.
- 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, and focused on specific treatment goals inclusive of the culture, expectations, and needs as identified by the youth and parent/caregiver.
- The individual 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.
- Group psychotherapy must be developmentally appropriate for the age of the youth and the group setting
- 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 engage the parent/caregiver in the youth's treatment to assure the youth's progress in treatment.
- It is the provider's responsibility to consult with other treating professionals and coordinate treatment with the managed care entity as necessary

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 (MD)

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

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

Supervising Practitioner Involvement

- **Supervision must be provided within the scope of practice of the individual supervising practitioner.**
- 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 that impaired 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 client's mental health treatment. The clinical record will contain the Pretreatment Assessment, assessment updates, the master treatment/recovery and discharge plan and treatment/recovery and discharge plan updates, group therapy progress notes, a complete record of supervisory contacts, narratives of other case management functions, and other information as appropriate. All client records of service must be readily available in English.

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

None allowed.

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 Group Psychotherapy – Child and 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 Outpatient Group Therapy.
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 in Group Therapy toward treatment goals.
4. The child/adolescent has an interpersonal problem due to their diagnosis and related functional impairments.
5. The child/adolescent has a therapeutic goal common to the group.

6. The child/adolescent may benefit from confrontation by, and/or accountability to, a group of peers.

Exclusion Guidelines:

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

1. The child/adolescent's treatment needs cannot reasonably be expected to be met by the level of structure and supervision offered by Outpatient Group Therapy.
2. The child/adolescent has a medical condition or impairment that warrants a medical/surgical setting for treatment.
3. 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.
4. 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.
5. Treatment for Pervasive Developmental Disorders and/or adaptive limitations from Pervasive Development Disorders is ineligible for Medicaid reimbursement.

Continuing 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.
10. The child/adolescent is motivated for continued treatment as evidenced by compliance with program rules and procedures.

Discharge Guidelines:

Any one of the following Guidelines is 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's attendance is at a level that renders continued outpatient group psychotherapy ineffective.
4. Consent for treatment is withdrawn by the parent or legal guardian.

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