

LEVEL I: Outpatient Group Therapy – Child and Adolescent SA

Definition

The following is based on 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 209-219. Providers are responsible to refer to the ASAM PPC-2R Youth Placement Manual for complete criteria.

Outpatient SA group therapy is the treatment of a DSM (current version) substance related diagnosis through scheduled treatment interventions with a common goal in the context of a group setting. A group is described as at least three and no more than twelve individual participants facilitated by a licensed practitioner. The focus of outpatient SA group therapy 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.

Treatment at this level of care may require coordination with other services such as additional psychiatric assessment and treatment, medical assessment and treatment, educational testing, juvenile justice probation, foster care, and/or human services.

Level I services are appropriate in the following situations:

- As an initial level of care when the severity of the illness warrants this intensity of intervention. Treatment should be able to be completed at this level, thus using only one level of care unless an unanticipated event warrants a reassessment of the appropriateness of this level of care.
- As a “step down” from a more intensive level of care
- As an alternative approach to engage the resistant individual in treatment, who is in the early stages of change and who is not yet ready to commit to full recovery. This often proves more effective than intensive levels of care that lead to increased conflict, passive compliance, or leaving treatment. If this approach proves successful, the patient may no longer require a higher intensity of service, or may be able to better use such service.

***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 substance abuse services are available to youth aged 20 and younger.

Program Requirements

Medicaid providers of substance abuse treatment services will adhere to all criteria outlined in the American Society of Addiction Medicine, Second Edition Revised (ASAM PPC-2R), or most current edition. 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.

Licensing/Accreditation

Substance abuse providers are responsible to verify the need for substance abuse licensure from the Department of Health and Human Services Division of Public Health Licensure unit prior to the delivery of 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. 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 including a substance abuse 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 SA therapy 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/recovery and 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 SA therapy 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 Alcohol and Drug Counselor (LADC)
- 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 prior to the initiation of treatment services.
- Provide face-to-face service to the client 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 substance abuse and/or mental health 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 individual's mental health and/or substance abuse treatment. The clinical record will contain the Pretreatment Assessment (including the substance abuse evaluation), assessment updates, the master treatment/recovery and discharge plan and treatment/recovery and discharge plan updates, therapy progress notes, a complete record of supervisory contacts, narratives of others 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.

ASAM criteria for youth apply when the treatment need is for addiction services only treatment and when the treatment need is for an individual who has co-occurring symptoms and diagnoses (mental health and substance abuse).

Clinical Guidelines: Level I: Outpatient Treatment – Child and Adolescent SA

Admission Criteria:

The youth/family is appropriately placed in a Level I program is assessed as meeting the diagnostic criteria for a substance-related disorder as defined in the current DSM as well as the dimensional criteria for admission.

- The youth/family appropriately placed at Level I in a Level I program is assessed as meeting requirements for ALL of the following six dimensions.
- Continued stay is determined by reassessment of criteria and the response of the person /family to treatment.

The following six dimensions and criteria are abbreviated. Providers are responsible to refer to the ASAM PPC-2R Adolescent PLACEMENT MANUAL for the complete criteria.

- **DIMENSION 1: ACUTE INTOXICATION AND/OR WITHDRAWAL:** The youth/family is not experiencing withdrawal acute or subacute withdrawal from alcohol or drugs and is not at risk for acute withdrawal or if the youth is experiencing mild withdrawal, the symptoms consist of no more than lingering but improving sleep disturbance.
- **DIMENSION 2: BIOMEDICAL CONDITIONS AND COMPLICATIONS:** In Level I, the youth/family is not posing any biomedical conditions or complications and therefore is sufficiently stable to permit participation in outpatient treatment.
- **DIMENSION 3: EMOTIONAL, BEHAVIORAL OR COGNITIVE CONDITIONS AND COMPLICATIONS:** Dangerousness – youth/family has adequate impulse control to deal with thoughts of harm to self or others. Youth's/family's treatment poses no problems in recovery efforts, social functioning, or ability for self-care. The youth's/family's mental status does not preclude his ability to understand materials presented nor to participate in treatment.
- **DIMENSION 4: READINESS TO CHANGE:** The youth/family status is characterized by one of the following:
 - Willingness to cooperate with the treatment plan and attend therapy sessions. A structured milieu not required; and
 - Youth/family acknowledges an alcohol or drug problem and wants help to change; however, is ambivalent about recovery efforts. Requires monitoring and motivation strategies; or
 - The youth/family has co-occurring mental and substance-related disorders and is able to acknowledge the psychiatric diagnosis but resistant to the substance use diagnosis or vice versa; or
 - The youth/family admits he or she has an alcohol or drug problem but is more invested in avoiding a negative consequence than in recovery efforts. The

youth/family requires monitoring and motivation strategies to help with engagement in treatment and to facilitate progress through stages of change.

- **DIMENSION 5: RELAPSE, CONTINUED USE OR CONTINUED PROBLEM POTENTIAL:** The youth/family is able to significantly reduce his or her substance use or to achieve and maintain abstinence and recovery goals with only minimum support. The youth/family needs regular therapeutic contact to help him or her deal with the issues that include but are not limited to: preoccupation with alcohol or other drug usage, craving, peer pressure or impulse control and lifestyle and attitudinal changes.
- **DIMENSION 6: RECOVERY ENVIRONMENT:**
 - The youth's/family's psychosocial environment is sufficiently supportive that outpatient treatment is feasible; or
 - The youth/family does not have the ideal primary or social support system to assist with immediate sobriety but has demonstrated motivation and willingness to obtain such a support system; or
 - The youth's family, guardian and/or caretaker are supportive but require professional interventions to improve the youth's/family's chances of treatment success and recovery. Interventions may involve assistance in monitoring and supervision techniques, limit setting and communication skills or a reduction in rescuing behaviors.

Exclusionary Guidelines:

1. N/A in ASAM. Please refer to admission and continued stay criteria as noted.
2. Treatment for Pervasive Developmental Disorders and/or adaptive limitations from Pervasive Developmental Disorders is ineligible for Medicaid reimbursement.

Continued Stay Guidelines:

It is appropriate to retain the individual at the present level of care if:

1. The individual/family is making progress but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at this level of care is assessed as necessary to permit the individual/family to continue to work toward their treatment goals.

OR

2. The individual/family is not yet making progress, but has the capacity to resolve his or her problems. The individual/family is actively working toward the goals in the individualized family treatment plan. Continued treatment at this level of care is assessed as necessary to permit the individual/family to continue to work toward their treatment goals.

AND/OR

3. New problems have been identified that are appropriately treated at this level of care. This level of care is the least intensive level of care at which the individual's/family's new problems can be addressed effectively.

To document and communicate the individual's/family's readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the individual's/family's existing or new problem (s), he or

she should continue in treatment at the present level of care. If not, refer to the Discharge/Transfer Criteria.

Discharge/Transfer Criteria

It is appropriate to transfer or discharge the youth from the present level of care if he or she meets the following criteria:

1. The youth/family has achieved the goals articulated in his or her individualized family treatment plan thus resolving the problem(s) that justified admission to the present level of care and the youth/family has a comprehensive relapse plan in place which is individualized for the families specific needs.
OR
2. The youth/family has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan. Treatment at another level of care or type of service is therefore indicated.
OR
3. The youth/family has demonstrated a lack of capacity to resolve his or her problem(s). Treatment at another level of care or type of service is therefore indicated.
OR
4. The youth/family has experienced an intensification of his or her problem(s), or has developed a new problem(s), and can be treated effectively only at a more intensive level of care.

To document and communicate the youth's/family's readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the existing or new problem(s), the youth should be discharged or transferred, as appropriate.

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