

Outpatient Group Psychotherapy - Adult

Definition

Outpatient group psychotherapy is the treatment of psychiatric disorders through scheduled therapeutic visits between the therapist and the patient in the context of a group setting of at least three and no more than twelve individual participants with a common goal. The focus of outpatient group psychotherapy treatment is to improve an individual's ability to function as well as alleviate symptoms that may significantly interfere with their functioning. Group therapy must provide active treatment for a primary DSM (current version) diagnosis. The goals, frequency, and duration of outpatient group treatment will vary according to individual needs and response to treatment.

***Groups that are educational or supportive in nature do not meet the definition of outpatient group psychotherapy for Medicaid and, as such, are not reimbursable**

Policy

Outpatient mental health services are available to Medicaid Managed Care eligible adult members, age 21 and over.

Program Requirements

Refer to the program standards common to all levels of care/programs for general requirements. All therapeutic groups must be approved by the ASO/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 may be provided in an office, clinic or other locations appropriate to the professional provision of group psychotherapy in groups of at least 3 and no more than 12 clients. Typical business hours are expected, with weekend and evening hours available to provide this service by appointment. The service must provide or otherwise demonstrate that members have on-call access to a mental health provider on a 24-hour, seven-day per week basis. Multiple therapies may need to be coordinated with the ASO.

Service Expectations

- A comprehensive bio-psychosocial assessment must be completed prior to the beginning of treatment and:
- The initial diagnostic interview must be conducted by a physician (psychiatrist preferred), psychologist, or licensed independent mental health practitioner (LIMHP) prior to the beginning of treatment
- Assessment should be ongoing with treatment

- Individualized treatment/recovery plan, including discharge and relapse prevention, developed with the individual prior to the beginning of treatment (consider community, family and other supports), reviewed on an ongoing basis, and adjusted as medically indicated
- Assessments and treatment should address mental health needs, and potentially, other co-occurring disorders
- Provided as group psychotherapy
- Consultation and/or referral for general medical, psychiatric, and psychopharmacology needs
- It is the provider's responsibility to coordinate with other treating professionals

Staffing

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

- Licensed Mental Health Practitioner (LMHP)
- Provisionally Licensed Mental Health Practitioner (PLMHP)
- Licensed Independent Mental Health Practitioner (LIMHP)
- Licensed Psychologist
- Provisionally Licensed Psychologist
- Psychiatrist
- Advanced Practice Registered Nurse (APRN)
- Supervising Practitioner (Psychiatrist, Licensed Clinical Psychologist, Licensed Independent Mental Health Practitioner)

Supervising Practitioner Involvement

- Provide face-to-face service to the member at least annually or as often as medically necessary.
- Meet with the client face-to-face to complete the initial diagnostic interview
- Review the Biopsychosocial Assessment (Part I of the Pretreatment Assessment) which was completed by the therapist.
- 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 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) and the recommendations for treatment if ongoing treatment is necessary
- 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 condition. 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.

Length of Stay

Length of treatment is individualized and based on clinical criteria for admission and continued treatment, as well as the individual's ability to benefit from treatment.

Special Procedures

None allowed.

Clinical Guidelines: Outpatient Group Psychotherapy

Admission Guidelines:

All of the following Guidelines are necessary for admission:

1. The individual demonstrates symptomatology consistent with a DSM (current version) diagnosis which requires and can reasonably be expected to respond to group therapeutic intervention.
2. The individual participant has an interpersonal problem related to their diagnosis and functional impairments.
3. There is an expectation that the individual has the capacity to make significant progress toward treatment from interaction with others who may have a similar experience.
4. The individual has the competency to function in a group therapy.
5. The individual has a therapeutic goal common to the group.

6. The individual 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 individual is grossly psychotic, a danger to themselves or others, or unable to tolerate the group process for any reason.
2. Group interaction may accelerate an acute condition.
3. The individual's goal is educational or supportive in nature.

Continuing Stay Guidelines:

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, and no less intensive level of care would be appropriate.
3. Treatment planning is individualized and appropriate to the individual'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 symptoms or impairments 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 individual's behavioral and functional outcomes as described in the discharge plan.
7. There is documented active discharge planning.

Discharge Guidelines:

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

1. The individual's documented treatment plan goals and objectives have been substantially met.
2. The individual no longer meets admission Guidelines, or meets Guidelines for a less or more intensive level of care.
3. The individual, is noncompliant in treatment. The noncompliance is of such degree that treatment at this level of care is rendered ineffective or unsafe in the clinical judgment of the treating professional. Non-compliance remains at this degree despite multiple, documented attempts to address non-compliance issues.
4. The individual's therapeutic goals are no longer common to the group.
5. Consent for treatment is withdrawn.