

Outpatient Individual Psychotherapy - Adult

Definition

Outpatient psychotherapy is the treatment of psychiatric disorders through scheduled therapeutic visits between the therapist and the individual. The focus of outpatient psychotherapy treatment is to improve symptoms that may significantly interfere with functioning in at least one life domain (e.g., familial, social, occupational, educational, etc.). The goals, frequency, and duration of outpatient treatment will vary according to individual needs and response to treatment.

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 additional 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

Outpatient psychotherapy services may be provided in an office, clinic or other professional service environment. Typical business hours, with weekend and evening hours available to provide this service by appointment. This service may be provided in the client’s home under specific conditions of need. (“Homebound” is defined as an individual whose medical or psychiatric condition restricts their ability to leave home safely without the assistance or supervision of another individual or without the assistance of a supportive device.) The service provider 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.

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 individual 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
- Advanced Practice Registered Nurse (APRN)
- Psychiatrist
- 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 every 90 days for the fully licensed therapist, 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 any 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, therapy progress notes, a complete record of supervisory contacts, narratives of others 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 client's ability to benefit from individual treatment/recovery goals.

Special Procedures

None allowed.

Clinical Guidelines: Outpatient Individual Psychotherapy

Admission Guidelines:

All of the following Guidelines are necessary for admission:

1. The individual demonstrates symptomatology consistent with a DSM (current edition) diagnosis which requires and can reasonably be expected to respond to therapeutic intervention.
2. There are significant symptoms that interfere with the individual's ability to function in at least one life area.
3. There is an expectation that the individual has the 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 individual requires a level of structure and supervision beyond the scope of non-programmatic outpatient services.

2. The individual has medical conditions or impairments that warrant a medical/surgical setting for treatment.
3. The primary problem is social, educational economic (i.e. housing, family, conflict, etc.), or one of physical health without a concurrent major psychiatric episode meeting Guidelines for this level of care, or admission is being used as an alternative to incarceration.
4. Treatment plan is designed to address goals other than the treatment of active symptoms of DSM diagnosis (e.g. self-actualization).

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. When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated.
8. 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/family's documented treatment plan goals and objectives have been substantially met.
2. The individual/family no longer meets admission Guidelines, or meets Guidelines for a less or more intensive level of care.
3. The individual, family, guardian and/or custodian is competent and 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. Consent for treatment is withdrawn.