

Outpatient Family Psychotherapy-Mental Health

Definition

Outpatient family psychotherapy is a therapeutic encounter between the licensed treatment professional and the individual (identified patient), the nuclear and/or the extended family. The specific objective of treatment must be to alter the family system to increase the functional level of the identified patient/family by focusing services/interventions on the systems within the family unit. This therapy must be provided with the appropriate family members and the identified patient (See “Family Therapy Without Member Present” for alternative special procedures).

Family psychotherapy services must:

- Be medically necessary for a mental health/substance condition
- Focus on the level of family functioning as a whole. Family psychotherapy would address issues related to the entire family system.
- Be recommended in the treatment recommendations of the Pretreatment Assessment (biopsychosocial assessment and the initial diagnostic interview). A complete Pretreatment Assessment includes a comprehensive family assessment
- Be based upon family focused goals and objectives that are clearly stated in the individualized treatment plan
- Support that the licensed therapist has an appropriate understanding of the family dynamics as evidenced in the content of the Pretreatment Assessment, treatment plan and the session progress notes
- Clearly identify in session progress notes the goals of the treatment plan and discharge plan as it relates to family psychotherapy
- Identify in session progress notes every family member involved in session, the date and start/end time of each family session

*Therapists of families 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 Medicaid Managed Care eligible adult members, age 21 and over.

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 disorder. 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.
- Family psychotherapy services must be a 60-minute session, at a minimum.

Program Requirements

Refer to the program standards common to all levels of care/programs 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

- Outpatient family psychotherapy services may be provided in an office, clinic or other professional service environment. Weekend and evening hours should be available by appointment. This service may be provided in the family’s home under specific conditions of need. The service must provide or otherwise demonstrate that members have on-call access to a licensed mental health provider on a 24-hour, seven-day per week basis.
- Outpatient family therapy may be conducted in addition to other outpatient therapy services as appropriate with documentation showing coordination of all services in the treatment record, and reviews by the supervising practitioner.

Service Expectations

- Assessment/Evaluation: A Biopsychosocial Assessment (including a detailed family assessment) must be completed prior to the implementation of outpatient family therapy treatment sessions. Assessments should address mental health needs, and potentially, other co-occurring disorders
- An initial diagnostic interview with the identified patient must occur prior to the implementation of treatment
- Assessment should be ongoing with treatment and reviewed each session.
- Treatment Planning: A goal-oriented treatment plan with measurable outcomes, and a specific, realistic discharge plan must be developed with the individual (identified patient) and the identified, appropriate family members as part of the initial assessment and outpatient family therapy treatment planning process; the treatment and discharge plan must be evaluated and revised as medically indicated as treatment continues.
- Consultation and/or referral for general medical, psychiatric, and psychopharmacology needs
- Provided as family psychotherapy

- 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. Mental health professionals specializing in the provision of family therapy are preferred but others may 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 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 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 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. *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 treatment is individualized and based on clinical criteria for admission and continued treatment, as well as the family's ability to benefit from treatment.

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

Clinical Guidelines: Outpatient Family Psychotherapy

Admission Guidelines:

Both criteria are met:

1. Involve the individual *and* his/her 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.
2. Family therapy 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

Continued Stay Guidelines:

All of the following Guidelines are necessary for continuing treatment:

1. Admission guidelines continue to be met.
2. Treatment planning is individualized and appropriate to the family's changing condition, with realistic and specific goals and objectives clearly stated.
3. All services and treatment are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice.
4. 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.
5. Care is rendered in a clinically appropriate manner and focused on the family's behavioral and functional outcomes as described in the discharge plan.
6. There is documented active discharge planning.

Discharge Guidelines

Any of the following Guidelines may be sufficient for discharge:

1. The family's documented treatment plan goals and objectives have been substantially met.
2. Admission guideline are no longer met.
3. The family members are 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 focus of therapy is no longer on the family system.
5. Consent for treatment is withdrawn.

Clinical Guidelines: Family Psychotherapy Without Member Present

(This service is offered only by exception: See Request for 90846, Family Therapy Without Member Present located in Appendix C of the Medicaid Provider Handbook

Admission Guidelines:

3. 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.
4. 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.

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 of the following Guidelines may be 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.