Residential: Individual and/or Family Psychotherapy

According to the Utah Medicaid Provider Manual (April 2015), 2-5: Psychotherapy,

Psychotherapy is the treatment for mental illness and behavioral disturbances in which the clinician through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development so that the client may be restored to his/her best possible functional level. Services are based on measurable treatment goals identified in the client's individualized treatment plan.

Who:
1. All psychotherapy may be performed by a licensed mental health therapist, an individual working within the scope of his or her certificate or license, or an individual exempted from licensure as a mental health therapist. (See Chapter 1-5, B. 1.)

***Individual psychotherapy** means in accordance with the definition of psychotherapy face-to-face interventions with the client and/or family member.*

Psychotherapy with patient and/or family member
Limits:
In accordance with the CPT manual, the following limits apply:
1. Psychotherapy times are for face-to-face services with the client and/or family member. The client must be present for all or some of the service. Procedure codes for psychotherapy with patient and/or family member are used when individual psychotherapy is being provided.
2. If family psychotherapy is prescribed as a service, use the procedure codes for family psychotherapy with patient present or family psychotherapy without patient present. See section below on procedure codes for family psychotherapy.

Record:
Documentation must include:
1. date, start and stop time, and duration of the service;
2. setting in which the service was rendered;
3. specific service rendered (i.e, psychotherapy with patient and/or with family member);
4. clinical note that documents:
a. individual(s) present in the session;
b. in accordance with the definition of psychotherapy, the focus of the psychotherapy session (i.e.,
alleviation of the emotional disturbances, reversal or change of maladaptive patterns of behavior, encouragement of personality growth and development); and
c. the treatment goal(s) addressed in the session and the client's progress toward the treatment goal(s), or if there was no reportable progress, documentation of reasons or barriers; or
5. If the focus of a psychotherapy visit with patient and or family member is a crisis or a reassessment/review of the client's overall treatment plan and 4.b. and/or 4.c. are not applicable, then the clinical note must summarize the crisis visit, including findings, mental status and disposition; or must summarize the reassessment findings and/or the review of the

treatment plan. Documentation for reviews of the treatment plan will include an update of the client's progress toward treatment goals contained in the treatment plan, the appropriateness of the services being prescribed, and the medical necessity of continued behavioral health services; and
6. signature and licensure or credentials of the individual who rendered the service.

***Family psychotherapy with patient present** means in accordance with the definition of psychotherapy face-to-face interventions with family members and the identified client with the goal of treating the client's condition and improving the interaction between the client and family members so that the client may be restored to their best possible functional level.*

***Family psychotherapy without patient present** means in accordance with the definition of psychotherapy face-to-face interventions with family member(s) without the identified client present with the goal of treating the client's condition and improving the interaction between the client and family member(s) so that the client may be restored to their best possible functional level.*

Family psychotherapy with patient present and family psychotherapy without patient present Record:
Documentation must include:
1. date, start and stop time, and duration of the service;
2. setting in which the service was rendered;
3. specific service rendered (i.e., family psychotherapy with patient present or family psychotherapy
without patient present)
4. clinical note that documents:
a. family members present in the session;
b. in accordance with the definition of psychotherapy, the focus of the family psychotherapy session (i.e., alleviation of the emotional disturbances, reversal or change of maladaptive patterns of behavior, encouragement of personality growth and development); and
c. the treatment goal(s) addressed in the session and progress toward the treatment goal(s), or if there was no reportable progress, documentation of reasons or barriers; or
5. If the focus of a family psychotherapy visit is a crisis or a reassessment/review of the overall treatment plan and 4.b. and/or 4.c. are not applicable, then the clinical note must summarize the crisis visit, including findings, mental status and disposition; or must summarize the reassessment findings and/or the review of the treatment plan. Documentation for reviews of the treatment plan will include an update of the client's progress toward treatment goals contained in the treatment plan, the appropriateness of the services being prescribed, and the medical necessity of continued behavioral health services; and
6. signature and licensure or credentials of the individual who rendered the service.