Outpatient Services

Providers contracted for this level of care or service are expected to comply with all requirements of these service-specific performance specifications.

The Outpatient Services performance specifications contained within pertain to organizational/facility-based outpatient providers, group practices, and individual practitioners.

They also apply to the following services which are a subset of Outpatient Services:

- Psychological Testing
- Dialectical Behavioral Therapy (DBT)

Please refer to the performance specifications for these specialty services below the standard Outpatient Services performance specifications.

Outpatient Services are behavioral health services that are rendered in an ambulatory care setting, such as an office, clinic environment, a Member's home, or other locations appropriate for psychotherapy or counseling, and/or the use of telehealth, including teletherapy and telepsychiatry. Services consist of time-effective, defined episodes of care that focus on the restoration, enhancement, and/or maintenance of a Member's optimal level of functioning, and the alleviation or amelioration of significant and debilitating symptoms impacting at least one area of the Member's life domains (e.g., family, social, occupational, educational). The goals, frequency, intensity, and length of treatment vary according to the needs of the Member and the response to treatment. A clear treatment focus, measurable outcomes, and a discharge plan including the identification of realistic discharge criteria are developed as part of the initial assessment and treatment planning process and are evaluated and revised as needed.

Components of Service

1. The scope of required service components provided in this level of care includes, but is not limited to, the following:
   a. Bio-psychosocial evaluation
   b. Provision of the following covered services:
      i. Diagnostic evaluation
      ii. Individual, couples, group and family therapy, including short-term, solution-focused outpatient therapy
      iii. Case and family consultation;
2. Outpatient Services providers provide the following:
   a. Psychopharmacology (including medication evaluation and ongoing medication monitoring and management)
   b. Psychological testing

3. Outpatient Services providers provide initial crisis response 24 hours per day, seven days per week, to all Members enrolled in the outpatient program/clinic/practice. These crisis responses are intended to be the first level of crisis intervention whenever needed by the Member.
   a. During operating hours, these crisis responses are provided by a clinician via telephone and, if clinically indicated, face-to-face through emergent appointments.
   b. After hours, the program provides Members with a telephone number that allows them to access a clinician either directly or via an answering service. That is, a live person must answer the phone number at all times.
   c. Calls identified as an emergency by the caller are immediately triaged to a clinician.
   d. A clinician must respond to emergency calls within 15 minutes and minimally provide a brief assessment and intervention by phone.
   e. Based upon these initial crisis responses conducted by the Outpatient Services provider both during operating hours and after hours, the provider may refer the Member, if needed, to an Adult Mobile Crisis Intervention (AMCI) provider for emergency behavioral health assessment, crisis intervention and stabilization.
   f. An answering machine or answering service directing callers to call 911 or the AMCI program, or to go to a hospital emergency department (ED), does not meet the after-hours emergency on-call requirements.
4. Outpatient Services providers ensure that each Member receives a program orientation describing the process of care, including after-hours emergency coverage, at the initiation of services.
5. Outpatient Services providers have documented policies and procedures, including those specific to the particular service being rendered (e.g., home-based, nursing facility, etc.). Also included is a documented policy and procedure for the management of no-shows and cancelations, which includes criteria for Member notification, outreach, and discharge.
6. Outpatient Services providers make best efforts to develop and maintain the capacity to serve Members with special needs in their communities (e.g., elders, those with developmental disabilities or cultural and linguistic needs, those who are homeless or who have co-occurring disorders, etc.). They adhere to their organizations' written protocols for treating such populations and/or offer appropriate referrals if they are unable to serve these Members directly. Outpatient Services providers that serve Members with severe and persistent mental illness develop and maintain a treatment model designed to meet their unique needs. The model includes approaches and information that support and facilitate Members' recovery-oriented principles and practices as well as linkages and coordination with a Member's primary care provider (PCP) and/or primary care team (PCT), appropriate state agencies, including the Department of Mental Health, consumer-operated and recovery-oriented services and supports, and natural resources.
7. Outpatient Services providers educate Members and, with informed consent and as clinically indicated, their families/caregivers/guardians/significant others about the use and risks of medication, symptom management, and recovery. When a Member begins to utilize psychopharmacology services through the Outpatient Services provider's organization, the

Outpatient Services provider engages in a medication reconciliation process in order to avoid inadvertent inconsistencies in medication prescribing that may occur, particularly in transition of a Member's prescribing from one provider or care setting to another. The Outpatient Services provider does this by reviewing with the Member, and, with Member consent, other treatment providers, the Member's complete medication regimen when the Member began treatment (e.g., transfer and/or discharge from another setting or prescriber), and comparing it with the regimen being considered in the Outpatient Services provider's organization in order to avoid medication errors. This involves:

a. Developing a list of current medications, i.e., those the Member was prescribed prior to beginning treatment at the Outpatient Services provider's organization;
b. Developing a list of medications to be prescribed in the Outpatient Services provider's organization;
c. Comparing the medications on the two lists;
d. Making clinical decisions based on the comparison and, when indicated, in coordination with the Member's PCP and/or PCT; and
e. Communicating the new list to the Member and, with consent, to appropriate caregivers, the Member's PCP and/or PCT and other treatment providers.

All related activities are documented in the Member's health record.

Staffing Requirements

1. Outpatient Services providers comply with the staffing requirements of the applicable licensing body, the staffing requirements in the Molina Healthcare, service-specific performance specifications, and the credentialing criteria outlined in the Molina Healthcare, Provider Manual as referenced at www.MolinaHealthcare.com.
2. Facility-based Outpatient Services providers make available to all Members a multi-disciplinary team appropriate to their needs and inclusive of licensed professionals as set forth in the DPH outpatient mental health licensing regulations, 105 CMR 140.000. For facility-based providers, the multi-disciplinary team, at a minimum, must include a psychiatrist (MD, DO), and at least two of the following (one of whom must be independently licensed):
   a. Psychologist (PhD, PsyD, EdD)
   b. Licensed independent clinical social worker (LICSW)
   c. Licensed clinical social worker (LCSW)
   d. Psychiatric Nurse
   e. Psychiatric nurse mental health clinical specialist (PNMHCS)
   f. Licensed mental health counselor (LMHC)
   g. Licensed supervised mental health counselor (LSMHC)
   h. Licensed alcohol and drug counselor (LADC1)
   i. Licensed marriage and family therapist (LMFT)
   j. Other Licensed Mental Health and Substance Use Disorder Practitioners
3. Outpatient Services providers provide all staff with supervision in compliance with

Molina Healthcare credentialing criteria.

4. Supervisory clinical staff must be available for consultation to staff during all hours of operation. Staff also have access to a psychiatrist, or a PNMHCS, for consultation as needed during operating hours.
5. Outpatient Services provided in an organizational/facility-based outpatient setting that employ master's level, unlicensed behavioral health professionals must be under the direct and continuous supervision of a fully qualified professional staff member trained in one of the core disciplines listed in 2.

Process Specifications

Access

1. Members who present with an urgent request for outpatient services but are determined not to be in crisis and not in need of immediate, emergent services, are offered an outpatient therapy appointment within **48** hours of the request. These Members are also given the Outpatient Services after-hours telephone number with appropriate emergency instructions.
2. Members with routine requests for outpatient services are offered an outpatient therapy appointment within **10** business days of the request.
3. Members referred from an inpatient unit are offered an outpatient therapy appointment (which may be an intake appointment for therapy services) within **7** calendar days from the date of discharge from the inpatient unit.
4. Members referred from an inpatient unit are offered a psychopharmacology appointment as soon as clinically indicated and within **14** calendar days from the date of discharge from the inpatient unit.
5. Outpatient Services providers are proactive and make best efforts to facilitate Member attendance at initial and ongoing appointments, such as via outreach and follow-up, reminder telephone calls or mailed notices, assistance with transportation arrangements, etc.
6. If the Member does not keep an appointment, the clinician follows the Outpatient Services provider's policies and procedures for the management of no-shows and cancelations, including documented attempts to contact the Member, family member and/or caregiver, if applicable and with Member's consent.
7. Outpatient Services providers make best efforts to offer operating hours that are responsive to the needs of Members and their families/caregivers, including a range of appointment days and hours, and offer evening and weekend appointments as possible and appropriate.

Assessment, Treatment Planning, and Documentation

1. When a newly referred Member, or a Member already receiving outpatient treatment at the Outpatient Services provider, has been evaluated by an Adult Mobile Crisis Intervention provider, and/or has been admitted to a 24-hour level of care, and/or when a Member is discharged from a 24-hour level of care, the Outpatient Services provider, with appropriate Member consent:
   a. Receives and returns phone calls from these providers as soon as possible and no later

than within one business day;
   b. Provides information and consultation in order to inform the assessment of the Member by the Adult Mobile Crisis Intervention provider and/or 24-hour level of care;
   c. Makes best efforts to participate, face-to-face or by telephone, in the 24-hour level of care treatment and discharge planning meetings;
   d. Provides bridge consultations for Members admitted to, or in the process of discharging from, 24-hour levels of care whenever possible;
   e. Facilitates the aftercare plan by ensuring access to outpatient therapy and psychopharmacology appointments that meet the access standards outlined above;
   f. Supports the Member in implementing his/her aftercare plan; and
   g. Documents all such activities in the Member's health record.
2. Outpatient Services providers collaborate with the Member, the Member's local Adult Mobile Crisis Intervention provider, and other clinical service providers such as discharging inpatient providers, to obtain the Member's crisis prevention plan and/or safety plan, as clinically indicated. Outpatient Services providers collaborate with the Member and these entities to update the plan if needed, or to develop one if the Member does not yet have one. The crisis prevention plan and/or safety plan is included in the Member's health record.
3. Outpatient Services providers ensure that comprehensive assessments and treatment plans are completed, in accordance with the Department of Public Health (DPH) regulations at 105 CMR140.520(C).
4. For facility-based providers, each Member's treatment plan is updated, and the treatment plan and progress is reviewed by one or more members of the multi-disciplinary team, at least annually. The frequency of treatment plan updates and multi-disciplinary case review is based upon the Member's current problems, specific and concrete goals, and treatment. Treatment plan updates, multi-disciplinary team case review, and any resulting treatment plan changes are documented in the Member's health record.
5. Group practices and individually contracted practitioners ensure that treatment plans are reviewed and updated at least annually and are documented in the Member's health record.
6. The frequency of reviewing and updating a given Member's treatment plan is based upon the Member's current problems, specific and concrete goals, and treatment.
7. Group practices document in the Member's health record evidence of multi-disciplinary consultation and coordination of care within the practice, including, but not limited to, such contact between treating clinicians and prescribers.
8. Individual practitioners document in the Member's health record evidence of clinical consultation as needed in treating specific Members, including but not limited to consultation and coordination of care with prescribers, including those with whom the practitioner maintains an Affiliation Agreement.

Discharge Planning and Documentation

1. Outpatient Services providers engage the Member in developing and implementing an aftercare plan when the Member meets the outpatient discharge criteria established in his/her treatment plan. Outpatient Services providers provide the Member with a copy of the plan upon his/her discharge, and document these activities in the Member's health record.

2. When the Outpatient Services provider, based on its policies and procedures for managing no shows and cancelations, determines that it is appropriate and necessary to terminate outpatient services with a Member, the Outpatient Services provider makes best efforts to initiate a thoughtful process, inclusive of the Member, aimed at facilitating his/her linkage with other services and supports, as needed. All such activities are documented in the Member's health record.
3. In preparation for discharge, and as clinically indicated, Outpatient Services providers ensure that the Member has a current crisis prevention plan and/or safety plan in place and that he/she has a copy of it. Outpatient Services providers work with the Member to update the plan he/she had obtained when the Member began treatment, or, if one was not available, develop one with the Member prior to discharge. With Member consent and as clinically indicated, Outpatient Services providers send a copy of the plan to the local Adult Mobile Crisis Intervention providers director at the Member's local Adult Mobile Crisis Intervention provider, other providers including the Member's PCP and/or PCT, and family members/significant others, and enter it in the Member's health record.

Service, Community, and Collateral Linkages

1. To facilitate continuity of care, Outpatient Services providers develop linkages and working relationships with other service providers frequently utilized by Members enrolled in their outpatient services, including Inpatient, primary care practices, and providers of diversionary and 24-hour levels of care.
   a. Included in these efforts, Outpatient Services providers develop working relationships with their local Adult Mobile Crisis Intervention providers, hold regular meetings or have other contact, and communicate with the Adult Mobile Crisis Intervention providers on clinical and administrative issues, as needed, to enhance bi-directional referrals and continuity of care for Members. On a Member-specific basis, Outpatient Services providers collaborate with the Adult Mobile Crisis Intervention provider when a Member has received Adult Mobile Crisis Intervention services, to ensure the Adult Mobile Crisis Intervention evaluation and treatment recommendations are received, and that any existing crisis prevention plan and/or safety plan is obtained from the Adult Mobile Crisis Intervention provider.
   b. These efforts to develop relationships with other service providers are documented through written Affiliation Agreements, MOU, and/or evidence of collaboration in Members' health records.
2. Outpatient Services providers utilize case consultation and family consultation to involve caregivers in the planning, assessment, and treatment for Members, as clinically indicated, and to educate them on mental health and substance use disorder treatment and relevant recovery issues. Additionally, with Member consent and as applicable, Outpatient Services providers utilize case consultation to involve the collaterals identified in the planning, assessment, and treatment for Members. All such activities are documented in the Member's health record.

3. With Member consent, the provider collaborates with the Member's PCP and/or PCT, and develops the behavioral health section of the Member's Individual Plan of Care.

Case Consultation

1. Case consultation is a documented meeting of at least 15 minutes' duration, either in person or by telephone, between the treating provider and other behavioral health/medical clinicians or physician, concerning a Member who is a client of the BH provider.
2. Goals of case consultation are to identify and plan for additional services, coordinate a treatment plan, review the individual's progress, and revise the treatment plan, as required.
3. The scope of required service components provided includes, but is not limited to the following:
   a. Treatment coordination
   b. Treatment planning
   c. Assessment of the appropriateness of additional or alternative treatment
   d. Clinical consultation (which does not include supervision)
   e. Second clinical opinion
   f. Aftercare planning
   g. Termination planning
4. Case consultation shall not include clinical supervision or consultation with other clinicians whom provide the same service at the same agency. The meeting could take place between two outpatient providers who work for different agencies, between the treating outpatient provider and any behavioral health provider offering services at a different level of care, or between the treating outpatient provider and a representative from the state, medical office, or residential provider.

Family Consultation

1. Family consultation is a documented meeting of at least 15 minutes' duration, either in person or by telephone, between the treating provider and with family members/caregivers or others who are significant to the member and clinically relevant to a Member's treatment.
2. Goals of family consultation are to educate, identify and plan for additional services or resources, coordinate a treatment plan, review the individual's progress, or revise the treatment plan, as required.
3. The scope of required service components provided includes, but is not limited to, the following:
   a. Treatment coordination
   b. Treatment planning with the Member's family or identified supports
   c. Assessment of the appropriateness of additional or alternative treatment
   d. Aftercare planning
   e. Termination planning
   f. Supporting or reinforcing treatment objectives for the Member's care
4. The meeting is between the treating outpatient provider and Member-identified family, caregiver, or supports.

Dialectical Behavioral Therapy (DBT)

DBT providers agree to adhere to both the Outpatient Service performance specifications (described above) and to the DBT performance specifications contained within. Where there are differences between the Outpatient Services and DBT performance specifications, these DBT specifications take precedence.

DBT is a structured outpatient treatment as defined by Marsha Linehan, PhD (Linehan, et. al., Cognitive-Behavioral Treatment of Borderline Personality Disorder, New York: Guilford Press, 1993), which combines strategies from behavioral, cognitive, and other supportive psychotherapies. DBT services encompass individual therapy, DBT skills group, therapeutic consultation to the Member on the telephone, and the therapists' internal consultation meeting(s). Through an integrated treatment team approach to services, DBT seeks to enhance the quality of the Member's life through group skills training and individual therapy with a dialectical approach of support and confrontation. DBT is available for adults who meet the DSM-5 diagnosis for borderline personality disorder and who exhibit chronic para-suicidal behaviors.

Components of Service

1. The DBT program ensures there is a designated DBT primary therapist for each Member.
2. The DBT therapist follows the Linehan model in the provision of DBT services.
3. The scope of required service components provided in this level of care includes the following, offered to Members on a weekly basis:
   a. Individual therapy with a DBT-trained therapist
   b. DBT skills training group
   c. Telephonic, therapeutic consultation/support/coaching (24-hour) with the Member
4. The DBT program uses weekly internal consultation with individual and group therapists to review treatment and to facilitate DBT skill development.

Staffing Requirements

1. The provider complies with the staffing requirements of the applicable licensing body, the staffing requirements in the Molina Healthcare, service-specific performance specifications, and the credentialing criteria outlined in the Molina Healthcare, Provider Manual, as referenced at www.MolinaHealthcare.com.
2. The DBT program maintains sufficient staffing to deliver the service in accordance with the Linehan model.
3. The DBT program is comprised of a minimum of two DBT-credentialed therapists who oversee the provision of all DBT services.
4. There are sufficient staff to provide all components of service, including weekly individual therapy and group skills training, telephonic coaching, and crisis intervention as needed.
5. The skills training group is led by a DBT-credentialed therapist. The co-leader may be a master's-level therapist who has not met the DBT credentialing requirements.

6. DBT therapists have a demonstrated capacity to handle crises as they arise and make use of crisis prevention plans as needed.

Psychological and Neuropsychological Testing/Assessment

The following Psychological Testing/Assessment performance specifications are a subset of the Outpatient Services performance specifications. As such, Psychological Testing/Assessment providers agree to adhere to both the Outpatient Services performance specifications and to the Psychological Testing/Assessment performance specifications contained within. Where there are differences between the Outpatient Services and Psychological Testing/Assessment performance specifications, these Psychological Testing/Assessment specifications take precedence.

Psychological Testing/Assessment involves the culturally and linguistically competent administration and interpretation of standardized tests to assess a Member's psychological or cognitive functioning. Psychological tests are used to assess a Member's cognitive, emotional, behavioral, and intra-psychic functioning on the central assumption that individuals have identifiable and measurable differences that can be elicited by means of objective testing. The psychologist's aim is to obtain data from standardized, valid, and reliable instruments that:

- lead to an accurate diagnosis;
- allow for hypotheses to be generated about the Member's problems and difficulties in functioning; and
- point to effective treatment strategies.

Unless otherwise indicated, use of the term "psychological testing/assessment" refers to both psychological and/or neuropsychological testing/assessment procedures. Similarly, unless otherwise specified, the term "psychologist" refers to both psychologists and neuropsychologists interchangeably. The administration of a fixed, standard battery of tests is not considered medically necessary; thus, the process approach of selecting specific tests that are directly responsive to the referral questions and presenting problems is generally endorsed by Molina Healthcare. (A fixed, standard battery is one that is either given to all Members regardless of diagnostic question, or a battery of tests given, for example, to all new Members.) Tests must be published, valid, and in general use as evidenced by their presence in the current edition of the Mental Measurement Yearbook, or by their conformity to the Standards for Educational and Psychological Tests of the American Psychological Association. Tests are administered individually and are tailored to the specific diagnostic questions of concern.

Components of Service

1. To ensure that Psychological Testing/Assessment occurs within the context of a comprehensive treatment/service plan, the psychologist generally performs testing that is requested by the individual clinician providing mental health and/or substance use disorder treatment. The psychologist may accept a referral from a source other than a treating

clinician; however, these referrals must be considered within the overall context of the Member's mental health and/or substance use disorder treatment plan.
2. When the referral is from a source other than a treating clinician, psychologists are generally required to conduct a diagnostic evaluation for clinically driven test requests prior to requesting authorization for the testing.
3. Services are available during normal business hours. Evening hours are regularly scheduled to maximize access for Members.
4. A licensed psychologist personally administers and evaluates all testing of Members. A licensed psychologist evaluates the results and prepares a comprehensive report that is shared orally (when feasible) and in written form with the referral source.
5. When computerized testing is administered by a trained bachelor's- or master's-level testing technician, the supervising licensed psychologist attests to the quality of the assessment by their signature on the report.
6. The psychologist maintains health records that cite reason(s) for referral, complete documentation of test(s) provided, test results, and interpretation of the results.
7. Psychologists are required to follow testing certification criteria for Psychological Testing.
8. In carrying out the assessment process, providers demonstrate careful, thorough, and thoughtful observation and interviewing of the Member. As part of this initial process, psychologists review the results and dates of previous testing, are clear about the questions being asked, and are aware of confounding variables such as medical illness or substance use.
9. The test should be focused on the resolution of an answerable, clearly stated clinical question that will inform treatment planning. More than one test of a general type is seldom indicated (e.g., two intelligence tests or two personality inventories). Neuropsychological assessment may be warranted when intelligence, personality, or other sources of information such as brief, cognitive measures suggest the possibility of organic impairment. Alternatively, neuropsychological assessment may be requested when there is known neurological dysfunction or injury for the purpose of determining functional strengths/weaknesses or changes.

Process Specifications

Assessment, Treatment Planning, and Documentation

1. An appointment for Psychological Testing/Assessment is offered to Members within 10 business days of receiving authorization.
2. A licensed psychologist functioning in accordance with Molina Healthcare's credentialing criteria, administers Psychological Testing/Assessment based on diagnostic information from the referring clinician or from an initial diagnostic interview with the Member. This enables the psychologist to correctly select testing procedures that will target a particular clinical question. Psychological Testing/Assessment should only occur when it is clear that the clinical issue in question is best answered by psychological and/or neuropsychological testing/assessment, and that will inform related treatment/service planning.

3. Psychologists ensure that the following questions and issues can be justified in documentation for Psychological Testing/Assessment, including:
   a. Are the questions clear, and do they fit the clinical context?
   b. Will the tests answer the questions?
   c. Are all the selected tests needed?
4. As part of the initial assessment process before performing Psychological Testing/Assessment, the psychologist ensures that the assessment includes, but is not limited to, the following:
   a. Review of results and dates of previous testing
   b. Clarification of the questions being asked and that need to be addressed
   c. Awareness of confounding variables such as medical illness or substance use
5. Psychological Testing/Assessment is completed, and a full comprehensive report is made available within 20 business days of its completion.