

TREATMENT PLANNING

As outlined in the CBH Credentialing Manual

All providers must develop a policy and procedure on the development and construction of treatment plans to include the following requirements:

- reflect input from **all** disciplines and the consumer (interdisciplinary treatment plan development)
- document the admission date, the date of the initial treatment plan, the date of the present treatment plan, and the date of the subsequent treatment plan
- documentation of the expected duration of the treatment
- reflect behaviorally defined problem statements
- goals to be realistic, objective, stated in measurable terms, and behaviorally based
- strength-based and identify the strengths/barriers of the consumer on all treatment plans
- reflect the five (5) axes diagnosis
- reflect the methods of treatment
- reflect interventions and action steps
- reflect initial discharge planning
- identify how the consumer is involved in the treatment planning process
- identification of persons responsible for the implementation of interventions
- discuss the requirement to document progress towards (or lack thereof) goal attainment in updated plans
- active participation and signature of the primary caregiver (legal guardian, parent) and/or the consumer for the development of, **and** any changes to, the treatment plan
- statement of understanding on treatment plans (initial and updated) be signed by the consumer (*if capable*)
- require treatment plans to be LEGIBLE
- ***For children's services only:*** Policy language that discusses how the educational needs of the consumer are provided when treatment causes an absence from school

CBH Credentialing Manual pp. 59-60

Compliance analysts will review documentation to ensure treatment plans are present, completed and updated within required timeframes, and contain all required elements and signatures. Treatment plans included in the records must have original signatures. Payment for all services provided without a valid treatment plan will be retracted.

MENTAL HEALTH SERVICES

23-HOUR ASSESSMENT BED

Initial Treatment Plan Due: Ongoing clinical documentation is to reflect “continued evaluation over an extended period of time beyond the initial emergency psychiatric evaluation to further evaluate for the most appropriate level of care.”

Treatment Plan Updates Due: Ongoing clinical documentation to reflect discharge planning

Required Signatures: As required for clinical documentation

Reference: 3.6 Authorization and Review Process for the 23-Hour Assessment, Utilization Management Guide, City of Philadelphia Behavioral Health System © 2000

PSYCHIATRIC INPATIENT HOSPITALIZATION

- ACUTE PSYCHIATRIC INPATIENT HOSPITALIZATION
- SUB-ACUTE PSYCHIATRIC INPATIENT HOSPITALIZATION
- EXTENDED ACUTE CARE (EAC)

Initial Treatment Plan Due: Within 72 hours

Treatment Plan Updates Due: At minimum every 14 days

Reference: **(WE EXCEED STATE MINIMUMS AND THIS WILL BE A CHANGE FROM THE CURRENT CBH CREDENTIALING MANUAL WHICH STATES:** Inpatient Mental Health Treatment programs: every seven (7) days. **(CBH Cred Manual p. 59 <http://www.dbhids.org/assets/Forms--Documents/credentialingmanual.pdf>)**

55 PA Code § 1151.65

PLAN OF CARE:

(A) Before authorization for payment for care provided to a recipient 21 years of age or older, the attending or staff physician shall establish, and include in the recipient's medical record, an individual written plan of care. The plan of care shall be designed to maintain the recipient at or restore the recipient to the greatest possible degree of health and independent functioning. The plan shall include:

1. Diagnoses, symptoms, complaints and complications indicating the need for admission.
 - Treatment objectives.
 - A description of the functional level of the individual.
 - Orders for medications, treatments, restorative and rehabilitative services, activities, therapies, social services and diet.
 - Special procedures recommended for the health and safety of the patient.
 - Plans for continuing care, including review and modification to the plan of care.
 - Plans for discharge.

(B) If a recipient is under age 21, an individual written plan of care designed to achieve the recipient's discharge from inpatient status at the earliest possible time shall be included in the recipient's medical record. The plan shall:

1. Be developed and implemented within 14 days after admission.

2. Be based on the diagnostic evaluation of the recipient that includes examination of the medical, psychological, social, behavioral and developmental aspects of the individual's condition and medical need for inpatient psychiatric care.
3. Be developed by the interdisciplinary team of professionals under 55 PA Code § 1151.66 (relating to team developing plan of care) in consultation with the recipient and those in whose care the recipient will be placed upon discharge.

STATE TREATMENT OBJECTIVES:

(A) Prescribe an integrated program of therapies, activities and experiences designed to meet the objectives in paragraph (4).

(B) Include, at an appropriate time, post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the recipient's family, school and community upon discharge.

(C) Subsections (a) and (b) apply only to private psychiatric hospitals. Distinct part psychiatric units of acute care general hospitals shall comply with 42 CFR 456.80 (relating to individual written plan of care).

55 PA Code § 5100.13.

RESPONSIBILITY FOR FORMULATION AND REVIEW OF TREATMENT PLAN:

(A) The director of the treatment team shall assure that staff trained and experienced in the use of the modalities proposed in the treatment plan participates in its development, implementation and review.

The director of the treatment team shall be responsible for:

1. Insuring that the person in treatment is encouraged to become increasingly involved in the treatment planning process.
2. Implementing and reviewing the individualized treatment plan and participating in the coordination of service delivery with other service providers.
3. Insuring that the unique skills and knowledge of each team member are utilized and that specialty consultants are utilized when needed.

(B) Although a treatment team must be under the direction of either a physician or a licensed clinical psychologist, specific treatment modalities may be under the direction of other mental health professionals when they are specifically trained to administer or direct such modalities.

Treatment Plan Updates Due 55 PA Code § 5100.16.

REVIEW AND PERIODIC REEXAMINATION:

(A) At least once every 30 days, every person in treatment under the act shall have his treatment plan reviewed. This review shall be based upon section 108(a) of the act (50 P. S. 55 PA Code § 7108(a)). A report of the review and findings shall be summarized in the patient's clinical record.

(B) The decisions and redispotion required by section 108(b) of the act, based upon such reexamination and review, shall be recorded in the patient's clinical record as either a progress note or in any other appropriate form acceptable to the agency's records committee.

(C) Such record shall include information required by section 108(c) of the act.

- (A) This chapter applies to all involuntary treatment of mentally ill persons, whether inpatient or outpatient, and for all voluntary inpatient treatment of mentally ill persons.

55 PA Code § 5100.15.

CONTENTS OF TREATMENT PLAN:

- (A) A comprehensive individualized plan of treatment shall:
1. Be formulated to the extent feasible, with the consultation of the patient. When appropriate to the patient's age, or with the patient's consent, his family, personal guardian, or appropriate other persons should be consulted about the plan.
 2. Be based upon diagnostic evaluation which includes examination of the medical, psychological, social, cultural, behavioral, familial, educational, vocational, and developmental aspects of the patient's situation.
 3. Set forth treatment objectives and prescribe an integrated program of therapies, activities, experiences, and appropriate education designed to meet these objectives.
 4. Result from the collaborative recommendation of the patient's interdisciplinary treatment team.
 5. Be maintained and updated with progress notes, and be retained in the patient's medical record on a form developed by the facility and approved by the Deputy Secretary of Mental Health, as part of the licensing approval process.
- (B) The treatment plan shall indicate what less restrictive alternatives were considered and why they were not utilized. If the plan provides for restraints, the basis for the necessity for such restraints must be stated in the plan under Chapter 13 (relating to use of restraints in treating patients/residents).
- (C) Individual treatment plans shall be written in terms easily explainable to the lay person and a copy of the current treatment plan shall be available for review by the person in treatment.
- (D) When the most appropriate form of treatment for the individual is not available or is too expensive to be feasible, that fact shall be noted on the treatment plan form.

PSYCHIATRIC INPATIENT HOSPITALIZATION
-ELECTROCONVULSIVE THERAPY

The treatment plan should define the specific target symptoms to be benefited by ECT, including alternative therapies that have been used or considered, and criteria for remission. ECT requires preauthorization from a CBH physician. A course of ECT is usually six (6) to twelve (12) treatments, administered three times a week or every other day. The total number of treatments should be a function of the patient's response and the severity of the adverse effects, if any.

Reference: *CBH Utilization Management Guide*, page 3.11

CRISIS RESIDENCE

Initial Treatment Plan Due: A medical examination and diagnosis is required for consumers housed over 24

hours. Initial treatment plan developed as outlined in provider policy; recommend within seven days. Policies should be available for auditors to review.

Treatment Plan Updates Due: When clinically indicated and as outlined in provider policy; recommend review at a minimum of every seven days

Required Signatures: Client, Mental Health Professional, Psychiatrist

Reference: PA Bulletin, Vol. 23, No. 10, March 6, 1993

5240.144.

PROVIDER RESPONSIBILITIES:

- (A) The provider shall ensure that individuals have medical clearance prior to placement in the facility.
- (B) Examination and evaluation. Assurance that a medical examination and diagnosis is made for consumers housed over 24 hours.

ACUTE PARTIAL HOSPITALIZATION PROGRAM – ADULT

Initial Treatment Plan Due: Within the first five (5) days of service

Treatment Plan Updates Due: When clinically indicated; at a minimum of once every 20 days of service to the individual patient

Required Signatures: The client and the treatment team (consists of a treatment team leader, a psychiatrist when the treatment team leader is not a psychiatrist and other appropriate staff).

Reference 55 PA Code § 5210.23.

TREATMENT PLANNING AND RECORDS:

An individualized treatment plan shall be formulated for patients in adult partial hospitalization programs by the patient's treatment team. A treatment team shall consist of a treatment team leader, a psychiatrist when the treatment team leader is not a psychiatrist and other appropriate staff. The treatment team leader shall be a mental health professional. For patients undergoing involuntary treatment, the treatment team leader shall be a physician or psychologist.

55 PA Code § 5210.25.

CONTENTS AND REVIEW OF A COMPREHENSIVE TREATMENT PLAN:

The treatment plan shall include the following:

- (A) Be formulated to the extent possible, with the cooperation and consent of the patient, or a person acting on his behalf.
- (B) Be based upon diagnostic evaluation which includes examination of the medical, psychological, social, cultural, behavioral, familial, educational, vocational and developmental aspects of the patient's situation.
- (C) Set forth treatment objectives and prescribe an integrated program of therapies, activities, experiences and appropriate education designed to meet these objectives.

- (D) Be maintained and updated with signed daily notes, and be kept in the patient's medical record or a form developed by the facility.
- (E) Be developed within the first 5 days of service and reviewed by the treatment team a minimum of once every 20 days of service to the individual patient and modified as appropriate.

ACUTE PARTIAL HOSPITALIZATION – CHILD/ADOLESCENT

Initial Treatment Plan Due: Within the first five (5) days of service

Treatment Plan Updates Due: A minimum of once every 20 days of service

Required Signatures: Client (Parent/Guardian if child under 14-years old), Psychiatrist, Treatment Team

Reference: 55 PA Code § 5210.33.

TREATMENT PLANNING AND RECORDS:

An individual treatment plan shall be formulated for all patients in children and youth partial hospitalization programs by the patient's treatment team. A treatment team shall consist of a treatment team leader, a psychiatrist and other appropriate staff of the treatment program. The treatment team leader shall be a mental health professional. For patients undergoing involuntary treatment, the treatment team leader shall be a physician or psychologist. Treatment plans shall be reviewed with parents or guardians of persons in children and youth partial programs if appropriate.

55 PA Code § 5210.35.

CONTENTS AND REVIEW OF A COMPREHENSIVE TREATMENT PLAN:

The treatment plan shall:

- (A) Be formulated to the extent possible, with the cooperation and consent of the patient or a person acting on his behalf.
- (B) Be based upon diagnostic evaluation which includes examination of the medical, psychological, social, cultural, behavioral, familial, educational, vocational, and developmental aspects of the patient's situation.
- (C) Set forth treatment objectives and prescribe an integrated program of therapies, activities, experiences and appropriate education designed to meet these objectives and staff assignments.
- (D) Be maintained and updated with signed daily notes, and be kept in the patient's medical record on a form developed by the facility.
- (E) Treatment plans for children and youth partial hospitalization programs shall be developed within the first 5 days of service and reviewed by the treatment team and psychiatrist a minimum of once every 20 days of service and modified as appropriate. Such modification shall be recorded in the patient's record.

55 PA Code § 5210.35. ↓ IS THIS A DUPLICATE SECTION? ↓

CONTENTS AND REVIEW OF A COMPREHENSIVE TREATMENT PLAN:

The treatment plan shall:

- (A) Be formulated to the extent possible, with the cooperation and consent of the patient or a person acting on his behalf.

- (B) Be based upon diagnostic evaluation which includes examination of the medical, psychological, social, cultural, behavioral, familial, educational, vocational, and developmental aspects of the patient's situation.
- (C) Set forth treatment objectives and prescribe an integrated program of therapies, activities, experiences and appropriate education designed to meet these objectives and staff assignments.
- (D) Be maintained and updated with signed daily notes, and be kept in the patient's medical record on a form developed by the facility.
- (E) Treatment plans for children and youth partial hospitalization programs shall be developed within the first 5 days of service and reviewed by the treatment team and psychiatrist a minimum of once every 20 days of service and modified as appropriate. Such modification shall be recorded in the patient's record.

↑ IS THIS A DUPLICATE SECTION? ↑

RESIDENTIAL TREATMENT FOR ADULTS

- RESIDENTIAL TREATMENT FACILITY FOR ADULTS (RTFA)

Historically we have used the RTF Guidelines (provided in this section as well)

Preliminary plan: Within 24 hours of admission. Comprehensive plan (ISP) within 14 calendar days of admission

Treatment Plan Updates Due: At least every 30 days

Required Signatures: Client (Parent/Guardian if child under 14-years old), Physician, Treatment Team

RESIDENTIAL TREATMENT FACILITIES (RTF)

- CHILD/ADOLESCENT

Initial Treatment Plan Due: Preliminary plan within 24 hours of admission. Comprehensive plan (ISP) within 14 calendar days of admission

Treatment Plan Updates Due: At least every 30 days

Required Signatures: Client (Parent/Guardian if child under 14-years old), Physician, Treatment Team

Reference:[40 Pa.B. 6109] [Saturday, October 23, 2010]

55 PA Code § 23.223.

DEVELOPMENT OF THE ISP:

- (A) A preliminary treatment plan addressing a child's behavioral health needs shall be completed within 24 hours of admission.
- (B) An ISP shall be developed for a child within 14 calendar days of a child's admission and include the following:
 1. A comprehensive strengths-based treatment plan addressing the behavioral health needs of a child and based on a diagnostic evaluation and the information related to a child's trauma screen and history demonstrating that trauma-related factors are being addressed in clinical treatment.

2. Medical needs of a child, including medications.
3. Psychological, social, behavioral and developmental needs of a child that reflects the need for RTF admission.

(C) The ISP shall be developed by an ISPT, an independent team comprised of the following:

1. The child.
2. The child's parents and, when applicable, the child's guardian or custodian.
3. A person invited by the child or the child's parent.
4. A contracting agency representative.
5. A representative of the county Mental Health/Mental Retardation Program.
6. A prescribing or treating psychiatrist or other clinician who will be working with the child.
7. A representative of the CCYA or JPO if the child is in the child welfare or juvenile justice system.
8. A child's Behavioral Health MCO.
9. A representative of the responsible school district if written parental consent has been obtained.
10. A physician.

(D) The treatment plan portion of the ISP addressing a child's behavioral health needs shall be developed by the treatment team, which must be an interdisciplinary team of physicians and other personnel who are employed by, or provide services to children in, the RTF.

1. The treatment team shall:
 - i. Assess a child's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and limitations.
 - ii. Assess the potential resources of a child's family.
 - iii. Set treatment objectives.
 - iv. Prescribe therapeutic modalities to achieve a plans objective.
2. The treatment team must include a board-eligible or board-certified psychiatrist and one of the following:
 - i. A psychiatric social worker.
 - ii. An RN with specialized training or 1 year of experience in treating children with a serious mental illness or emotional or behavioral disorder.
 - iii. A licensed occupational therapist who has specialized training or one year of experience in treating children with a serious mental illness or behavioral disorder.

- iv. A psychologist who has a master's degree in clinical psychology or who has been licensed by the Commonwealth.
- (E) At least 3 phone or written contacts shall be made at least 2 weeks in advance to invite the child and the child's parent and, when applicable, a guardian or custodian, to participate in the development of the ISP at a time and location convenient for the child and the child's parent, and when applicable, the child's guardian or custodian, and the RTF.
- (F) Documentation of a contact made to involve a child's parent and, when applicable, guardian or custodian shall be kept in the child's record.
- (G) Persons who participated in the development of the ISP shall sign and date the ISP, with the exception of the child, the child's parent and, when applicable, the child's guardian or custodian, who shall be given the opportunity to, but are not required to, sign the ISP. Disagreement with the ISP or refusal to sign the ISP shall be documented in the child's record.

55 PA Code § 23.224.

CONTENT OF THE ISP:

(A) An ISP should reflect the needs, strengths, culture and priorities of a child and the child's family, and include the following:

1. A treatment plan that is written in language understandable to the child and the child's family, and includes the following:
 - i. Developmentally appropriate, asset-building treatment goals and objectives, such as building functional competencies.
 - ii. Biologic, psychological and social interventions.
 - iii. The child's identified priorities.
 - iv. The environments in which the child exhibits a behavioral health treatment need.
 - v. An explanation of the appropriate settings and time allocations for an intervention.
 - vi. A detailed description of changes or updates from previous treatment plans.
 - vii. Documentation of the continued clinical need for the service.
 - viii. Detailed information to assist the staff with a comprehensive understanding of the specific interventions and objectives with which the staff will be assisting a child in attaining goals.
2. Evaluation of the child's skill level for a goal.
3. Monthly documentation of the child's progress on each goal.
4. Services and training that meet the child's needs, including the child's needs for safety, competency development and permanency.
5. A component addressing family involvement including, when applicable, the collaborative efforts with a High-Fidelity Wraparound Team.

6. A plan to teach the child health and safety skills including the following:
 - i. Nutrition and food selection.
 - ii. Exercise.
 - iii. Physical self-care.
 - iv. Sleep.
 - v. Coping skills.
 - vi. Relaxation approaches.
 - vii. Personal interests for constructive use of leisure time.
 - viii. Substance use and abuse.
 - ix. Personal safety.
 - x. Healthy interpersonal relationships.
 - xi. Services to others.
 - xii. Decision-making skills.
7. A component addressing how a child's education needs will be met in accordance with applicable Federal and State laws and regulations.
8. The anticipated duration of the stay at the RTF.
9. Discharge and aftercare plan to be addressed during monthly treatment team meetings and during ISPT meetings to ensure continuity of care with a child's family, school and community upon discharge.
10. Methods to be used to measure progress on the ISP, including who is to measure progress and the objective criteria to be used.
11. The name of the person responsible for coordinating the implementation of the ISP.
12. Medical needs, including medication.

55 PA Code § 23.225.

REVIEW AND REVISION OF THE ISP:

- (A) A review of a child's progress on the ISP, and a revision of the ISP if needed, shall be completed at least every 30 days.
- (B) A child's ISP shall be revised if one of the following occur:
 1. There has been no progress on a goal.

2. A goal is no longer appropriate.
 3. A goal needs to be modified.
 4. A goal needs to be added.
- (C) A review and revision of the ISP shall be completed in accordance with *55 PA Code § 23.223(b)(1)* (relating to development of the ISP.)
- (D) An RTF shall notify and invite a child's parents and, when applicable, a guardian or custodian, to participate in the review of the ISP and consider making changes based on a child's clinical course. Parent, and when applicable, guardian or custodian involvement is also to be obtained for a change in type of psychotropic medication.
- (E) A child and the child's parent and, when applicable, guardian or custodian, shall contribute to the development, review and revision of a child's ISP.

LONG TERM STRUCTURED RESIDENTIAL (LTSR)

Initial Treatment Plan Due: Initial plan within 72 hours , comprehensive treatment plan within 10 days of admission

Treatment Plan Updates Due: At least every 30 days or more frequently as the resident's condition changes

Required Signatures: The client and the interdisciplinary treatment team

Reference *55 PA Code § 5320.51.*

TREATMENT PLAN:

The interdisciplinary treatment team shall:

- (A) Complete an initial assessment, on admission by the interdisciplinary team of the resident's mental, physical and social needs including a mobility assessment.
 1. Reflect the reason for the resident's admission.
 2. Indicate what less restrictive alternatives to an LTSR were considered and why they were not utilized.
- (B) Develop an initial treatment plan, within 72 hours, based on the initial assessment by the interdisciplinary team.
- (C) The plan, developed with the participation of the resident or a designee, shall identify the problem areas, initial goals and objectives for the resident to meet, modalities of treatment, and responsible staff indicated in helping the resident meet their goals.
- (D) Develop a comprehensive treatment plan within 10 days of admission. The plan shall:
 1. Be formulated, to the extent feasible, with the participation of the resident. With the resident's consent, designated persons could participate in the planning process.
 2. Be based upon diagnostic evaluation of the resident's medical, psychological, social, cultural, behavioral, familial, educational, vocational and developmental strengths and needs.

3. Set forth measurable, time limited treatment goals and objectives and prescribe an integrated program of therapies, activities, experiences and appropriate education designed to meet these goals and objectives.
4. Specify the person responsible for carrying out the modalities described in the plan.
5. Result from the collaborative recommendation of the resident's interdisciplinary treatment team.
6. Be easily understood by a lay person and a copy of the current treatment plan shall be available for review by the person in treatment.
7. Address major psychiatric, psychosocial, medical, behavioral and rehabilitative needs of the resident and the manner in which they are to be met, including those needs to be addressed by contractors who are not employed by the LTSR.

55 PA Code § 5320.52.

REVIEW AND PERIODIC REEXAMINATION:

The interdisciplinary treatment team shall review treatment plans at least every 30 days or more frequently as the resident's condition changes. A report of the review and findings and the resident's progress toward meeting program goals and objectives shall be documented by the interdisciplinary team in the resident's record.

- (A) The interdisciplinary treatment team shall maintain a record of each reexamination and review to include:
 1. A report of the reexamination.
 2. A brief description of the treatment provided to the person during the period preceding the reexamination and the results of that treatment.
 3. Continuation or revision of the individual treatment plan for the next period.
 4. Criteria for discharge and recommendation for discharge if these criteria have been met.
- (B) Changes to the treatment plan and the reasons for the changes shall be made by the interdisciplinary treatment team and recorded in the resident's record as a progress note or on another form specifically designed for that purpose.
- (C) The record shall include information required by *55 PA Code § 5100.16* (relating to review and periodic reexamination).
- (D) Reassessment of each resident's mental, physical and social needs, including a mobility assessment as follows:
 1. Annually.
 2. If the condition of the resident materially changes prior to the annual assessment.
 3. At the request of the county administrator or the Department if there is cause to believe that an additional assessment is required.

COMMUNITY RESIDENTIAL REHABILITATION (CRR)

Initial Treatment Plan Due: The community residential rehabilitation service (CRRS) staff shall develop with each client an individualized written client residential service plan upon the client's enrollment in the CRRS.

Treatment Plan Updates Due: The CRRS staff shall evaluate the client's adjustment to the program within 30 days of enrollment and modify the service plan as needed. The residential service plan must be reviewed and updated every 60 days thereafter.

Required Signatures: Client and CRR staff

Reference: 55 PA Code § 5310.33.

RESIDENTIAL SERVICE PLAN:

- (A) The community residential rehabilitation service (CRRS) staff shall develop with each client an individualized written client residential service plan upon the client's enrollment in the CRRS.
- (B) The individual residential service plan must be based on the client's psychosocial evaluation which is a functional assessment of the client's strengths and needs in the major areas related to independence in residential and community functioning and addresses the client's:
 - 1. Self-care skills.
 - 2. Health care, including medication management.
 - 3. Housekeeping skills.
 - 4. Ability to meet nutritional needs.
 - 5. Mobility.
 - 6. Money management skills.
 - 7. Interpersonal skills.
 - 8. Vocational/educational pursuits.
 - 9. Use of leisure time.
 - 10. Time structuring.
 - 11. Community participation such as social networking and utilization of services and resources.
- (C) The residential service plan must include the following items:
 - 1. Short and long-term goals for service formulated jointly by the staff and client.
 - 2. Behaviors to be modified and skills to be developed.
 - 3. Type and frequency of rehabilitation services to be provided.
 - 4. Techniques and methods of service to be used.

5. A list of persons involved in the implementation of the plan.
- (D) The CRRS staff shall evaluate the client's adjustment to the program within 30 days of enrollment and modify the service plan as needed. The residential service plan must be reviewed and updated every 60 days thereafter.
 - (E) Each client in a CRRS must spend a major portion of his time out of the residence. The goal of such involvement outside the residence is to increase the client's use of community resources and participation in community activities which the client can continue to use upon program termination. The method for achieving this goal must be reflected in each client's residential services plan.
 - (F) The client shall participate in the goal-setting, service planning, decision-making and progress assessment associated with the service plan.
 - (G) The original residential service plan, subsequent plan revisions, written plan reviews and documentation of client participation must be included in the client record.
 - (H) At the time of enrollment into CRRS and throughout the service period, each client shall be assigned to a CRRS staff person who is responsible for assuring:
 1. In-residence services are provided according to the client's residential service plan.
 2. Referrals to and arrangements for service provision by other agencies specified in the client's residential service plan occur and are coordinated with the agency or agencies responsible for treatment/case management of the client, such as the Mental Health/Mental Retardation Base Service Unit, Veterans' Administration, Domiciliary Care, and therapist.
 3. Case recording of intake information, service plan, progress notes, service plan reviews, annual reassessment, referrals, and termination summary.
 - i. A complete reassessment of the client's strengths and needs as determined by the psychosocial evaluation and a review of the services provided to the client must be performed annually, or more frequently, if a significant change in the client's level of functioning occurs. The reassessment must take place at a conference which includes the persons involved in the individual service plan development and implementation. The results of this meeting must be documented in the case record and submitted in writing to the agency or agencies responsible for treatment and/or case management of the client.

COMMUNITY REHABILITATION RESIDENCE-HOST HOME (CRR-HH)

Initial Treatment Plan Due: Within 30 days of enrollment

Treatment Plan Updates Due: Every 60 days

Required Signatures: CRR staff with the child's parent, the agency having custody of the child, if applicable, and the child when the child is 14 years of age or older

Reference 55 PA Code § 5310.33.

RESIDENTIAL SERVICE PLAN:

- (A) The CRRS staff shall evaluate the client's adjustment to the program within 30 days of enrollment and modify the service plan as needed. The residential service plan must be reviewed and updated every 60 days thereafter.

RESIDENTIAL SERVICE PLAN:

- (A) Upon the child's enrollment, an individualized written client residential service plan shall be developed by the community residential rehabilitation service (CRRS) staff with the child's parent, the agency having custody of the child, if applicable, and the child when the child is 14 years of age or older. When the child is under 14 years of age the child may be included in the development of the individual residential service plan, as appropriate.
- (B) The service plan shall be based on an evaluation of the child's social and emotional development relative to age appropriate expectations for functioning in interpersonal relationships within the family, peer groups and the community. The service plan includes as needed:
 - 1. Self care skills.
 - 2. Health care, including medication management.
 - 3. Housekeeping skills.
 - 4. Ability to meet nutritional needs.
 - 5. Mobility.
 - 6. Money management skills.
 - 7. Interpersonal skills.
 - 8. Educational/vocational pursuits.
 - 9. Use of leisure time.
 - 10. Time structuring.
 - 11. Community participation.
- (C) The service plan must specify short and long-term goals for service formulated by staff and parent of the child, the agency having legal custody of the child, if applicable, and the child when the child is 14 years of age or older. When the child is under 14 years of age, the child may be included in specifying goals whenever possible.
- (D) The child's parent, the agency having custody of the child, if applicable, and the child shall participate in the goal-setting, service planning, decision-making and progress assessment associated with the service plan.
- (E) At the time of enrollment into CRRS and through the service period, each client must be assigned a primary staff person who is responsible for assuring that the residential service plan is coordinated with the service plans of other agencies having responsibility for specific facets of the child's life, for example, education agencies, children and youth agencies, base service units, juvenile justice system, and mental health service agencies.

- (F) Subsections (a)-(d) supersedes 55 PA Code § 5310.33(a), (b), (c)(1), and (f) (relating to residential service plan). Subsection (e) supersedes 55 PA Code § 5310.33(h). The requirement of 55 PA Code § 5310.33(e) does not apply to CRRS programs serving children.

OUTPATIENT MENTAL HEALTH

Initial Treatment Plan Due: Within 15 calendar days of intake.

Treatment Plan Updates Due: At least every 120 days or 15 clinic visits, whichever is first

Required Signatures: Client (parent if client age < 14 yo), Psychiatrist, Mental Health Professional

Reference 55 PA Code § 1153.52.

PAYMENT CONDITIONS FOR VARIOUS SERVICES:

- (A) Within 15 consecutive calendar days following intake, a mental health professional or mental health worker under the supervision of a mental health professional, shall examine and initially assess each patient in the clinic; determine the patient's diagnosis and prepare an initial treatment plan; and date and sign the examination, diagnosis and treatment plan in the patient's record.
1. The psychiatrist shall verify each patient's diagnosis and approve the treatment plan prior to the provision of any treatment beyond the 15th day following intake. This review and approval shall be dated and signed in the patient's record.
 2. The psychiatrist and mental health professional, or mental health worker under the supervision of a mental health professional, shall review and update each patient's treatment plan at least every 120 days or 15 clinic visits, whichever is first, or, as may otherwise be required by law throughout the duration of treatment. Each review and update shall be dated, documented and signed in the patient's record by the psychiatrist and mental health professional.

55 PA Code § 5200.31.

TREATMENT PLANNING:

- (A) A qualified mental health professional or treatment planning team shall prepare an individual comprehensive treatment plan for every patient which shall be reviewed and approved by a psychiatrist. For patients undergoing involuntary treatment, the treatment team shall be headed by a physician or psychologist. The treatment plan shall include the following:
1. Be based on the results of the diagnostic evaluation described in paragraph (7).
 2. Be developed within 15 days of intake, and for voluntary patients, be reviewed and updated every 120 days or 15 patient visits—whichever is first—by the mental health professional and the psychiatrist. For involuntary patients review shall be done every 30 days. Written documentation of this review in the case record is required.
 3. Specify the goals and objectives of the plan, prescribe an integrated program of therapeutic activities and experience, specify the modalities to be utilized and a time of expected duration and the person or persons responsible for carrying out the plan.
 4. Be directed at specific outcomes and connect these outcomes with the modalities and activities proposed.

5. Be formulated with the involvement of the patient.
6. For children and adolescents, when required by law or regulations, be developed and implemented with the consent of parents or guardians and include their participation in treatment as required.
7. Specify an individualized active diagnostic and treatment program for each patient which shall include where clinically appropriate services such as diagnostic and evaluation services, individual, group and family psychotherapy, behavior therapy, crisis intervention services, medication and similar services. For each patient the clinic shall provide diagnostic evaluation which shall include an assessment of the psychiatric, medical, psychological, social, vocational, and educational factors important to the patient.

TCM / BLENDED CASE MANAGEMENT / ASSERTIVE COMMUNITY TREATMENT

Initial Treatment Plan (Personal Goal Plan) Due: Within one (1) month of registration.

Treatment Plan Updates Due: Monthly Review. Comprehensive update every six (6) months.

Required Signatures: Client/guardian, case manager, and case management supervisor

Reference

55 PA Code § 5221.31.

- (A) Providing the intensive case management service in accordance with a written, consumer-specific service plan which includes strengths as well as needs and which is goal and outcome oriented. The outcomes, which shall be measured and reviewed at least every 6 months on an individual and systems basis, are:
1. Independence of living for the adult; or family integration, if the consumer is a child.
 2. Vocational/educational participation.
 3. Adequate social supports.
 4. Reduced hospital lengths of stay or child out-of-home placements.
- (B) Documenting at least quarterly the functioning level of each consumer.

55 PA Code § 5221.33

WRITTEN SERVICE PLAN:

(C) The initial plan shall:

1. Be developed within 1 month of registration and reviewed at least every 6 months.
2. Reflect documented assessment of the consumer's strengths and needs.
3. Identify specific goals, objectives, responsible persons, time frames for completion and the intensive case manager's role in relating to the consumer and involved others.
4. Be signed by the consumer, the family if the consumer is a child, the intensive case manager, the intensive case management supervisor and others as determined appropriate by the consumer

and the intensive case manager. If the signatures cannot be obtained, attempts to obtain them should be documented.

PSYCHIATRIC REHABILITATION SERVICES (CIRC, MOBILE PSYCH REHAB, CERTIFIED PEER SPECIALIST)

Initial Treatment Plan Due: A PRS agency shall complete an IRP by day 20 of attendance, but no more than 60 calendar days after initial contact.

Treatment Plan Updates Due: A PRS agency and an individual shall update the IRP at least every 90 calendar days and when:

- (A) A goal is completed.
- (B) No significant progress is made.
- (C) An individual requests a change.

Required Signatures: Dated signatures of the individual, the staff working with the individual and the PRS director.

Reference

55 PA Code § 5230.62.

INDIVIDUAL REHABILITATION PLAN:

- (A) A PRS staff and an individual shall jointly develop an IRP that is consistent with the assessment and includes the following:
 - 1. A goal designed to achieve an outcome.
 - 2. The method of service provision, including skill development and resource acquisition.
 - 3. The responsibilities of the individual and the staff.
 - 4. Action steps and time frame.
 - 5. The expected frequency and duration of participation in the PRS.
 - 6. The intended service location.
 - 7. Dated signatures of the individual, the staff working with the individual and the PRS director.
- (B) A PRS agency shall complete an IRP by day 20 of attendance, but no more than 60 calendar days after initial contact.
- (C) A PRS agency and an individual shall update the IRP at least every 90 calendar days and when:
 - 1. A goal is completed.
 - 2. No significant progress is made.
 - 3. An individual requests a change.
- (D) An IRP update must include a comprehensive summary of the individual's progress that includes the following:
 - 1. A description of the service in the context of the goal identified in the IRP.

2. Documentation of individual participation and response to service.
3. A summary of progress or lack of progress toward the goal in the IRP.
4. A summary of changes made to the IRP.
5. The dated signature of the individual.
6. Documentation of the reason if the individual does not sign.
7. The dated signature of the PRS staff working with the individual and the dated signature of the PRS director.

FQHC

Initial Treatment Plan Due: FQHC Behavioral Health service is a consultative model. Treatment plans do not necessarily need to be developed independently; the goal(s) can be devised during the session and documented within the progress note.

Treatment Plan Updates Due: The goal(s) for ongoing behavioral health services should be developed during the session and documented within the “Plan” section of the progress note. There is no delineated timeframe, as the chart may never technically close and clients do not necessarily come in for regularly scheduled visits.

Required Signatures: For ongoing behavioral health services, it is recommended for the client and clinician to sign off on treatment goals to indicate their understanding and agreement.

BEHAVIORAL HEALTH REHABILITATIVE SERVICES (BHRS, OR “WRAP AROUND”)

School based programs follow. Also changing that ALL STAFF assigned to the case must participate and sign the plans.

Initial Treatment Plan Due: Before services are started

Treatment Plan Updates Due: 120 Days

Required Signatures: Parent, Child (if 14-years old or older), and all BHRS staff assigned to the case (BSC, MT, TSS)

Reference: CBH Provider Bulletin #10-06 Notification regarding changes to the delivery of BHRS August 11, 2010. Recommendations from the BHRS Packet Reduction Workgroup:

- Intensive Professional Services “Providers are to complete and submit every 120 days an updated treatment plan to CBH along with a summary of progress in treatment”
- TSS School requests for up to 20 hours or less per week that meet medical necessity, without a request for non school TSS services, may be approved for the entire academic year.
 - “CBH will require Treatment Plans be completed and submitted every 120 days to monitor progress In treatment>>

MA Bulletin 01-94-01 “The treatment plan must be developed and updated at a minimum of every four months in collaboration with the child and family as clinically needed.”

MA Bulletin 01-02-07, 20-02-04, 33-02-04, 41-02-03, 48-02-02, 49-02-04, 50-02-02 Issue Date April 3, 2002, Effective Date March 1, 2002 (need to include text) 3.a. – 3.f.

BHRS/Autism

SCHOOL BASED PROGRAMS

- SCHOOL THERAPEUTIC SERVICES (STS)

Initial Treatment Plan Due: With authorization packet. If there is an existing CBE/CBR completed by another provider recommending STS, CBH can approve an initial authorization of STS Assessment for up to 4 weeks to allow sufficient time to observe and assess the need for behavioral health support, and to complete and submit the ASEBA and an updated treatment plan.

Treatment Plan Updates Due: STS has been approved as a program exception under BHRS, which allows the completion of evaluations, treatment plans, and plan of care summary to be done in 5-month time frames. A new treatment plan is required in September for carry over youth even if the STS authorization will be extended into the following academic year. STS providers have up to 30 days at the beginning of the school year to get the Treatment Plan updated and signed by the licensed psychologist or psychiatrist.

Required Signatures: Client (if 14-years or older), Parent, Licensed Psychologist or Psychiatrist

- THERAPEUTIC EMOTIONAL SUPPORT CLASSROOM (TESC)

Initial Treatment Plan Due: Before services are started (same requirements as BHRS)

Treatment Plan Updates Due: 120 Days

Required Signatures: Parent, Child (if 14-years old or older), and

Reference: MA Bulletin 01-94-01 (need to include text)

MA Bulletin 01-02-07, 20-02-04, 33-02-04, 41-02-03, 48-02-02, 49-02-04, 50-02-02 Issue Date April 3, 2002, Effective Date March 1, 2002 3.a. – 3.f.

- SUMMER THERAPEUTIC ACTIVITIES PROGRAM (STAP)

Initial Treatment Plan Due: Within two weeks of beginning service

Treatment Plan Updates Due: N/A

Required Signatures: Child (if age 14 and above), Parent, Lead Clinician

Reference: Medical Assistance Bulletin 50-96-03 "Summer Therapeutic Activities Program"

- (A) The provider must develop an individualized treatment plan based on an assessment of the strengths and therapeutic needs of the child and family. The assessment should include active listening, asking questions and exchanging information goals and objectives (in measurable terms) to be achieved by the child in the summer therapeutic activities program experience. These goals and objectives must be coordinated with the

overall treatment goals and service plan for the child. The treatment plan must identify the involvement of other child-serving agencies, other treatment staff, the lead clinician, and the lead case manager. The treatment plan also must demonstrate how this service is integrated into the overall interagency service plan for the child and family.

- (B) The provider must include the parents or other caretakers as members of the treatment team and as partners in the treatment team process. Such inclusion requires that the family actively participate in the formulation, development, implementation and monitoring of the treatment efforts; and presumes the family's broad knowledge about the child and the family's intention to contribute constructively to the positive outcomes.
- (C) The provider should involve significant family members in the program experience and activities, which may require some accommodation to parent or family member work to participate in the treatment team activities or other program activities should not preclude the participation of the child in the summer therapeutic activities program. Thorough documentation of the efforts to involve the parents or family members and the reasons for their non-participation must be included in the case record.
- (D) The provider must maintain a case record that includes referral information, medication regimen, the psychiatric or psychological evaluation that substantiates the medical need for the summer therapeutic activities program, and the recommendation of the interagency treatment team (including the list of participants, plan of care summary, and treatment plan) and legible progress notes. The progress notes must detail the child's response to the therapeutic activities and the relationship of that response to the treatment goals for the child. The mental health professional and/or the mental health worker who is assigned primary responsibility for the child must write, date and legibly sign the progress notes.

CONTINUUM OF FAMILY ORIENTED TREATMENT SERVICES **- FAMILY-BASED MENTAL HEALTH SERVICES (FBMHS)**

Initial Treatment Plan Due: A treatment plan must be initiated within five days from the first day of service; however, a longer period of time may be required to complete the treatment plan. A jointly-developed, written plan which documents the service responsibilities of each system must be included in the treatment plan within the first 30 days of service.

Treatment Plan Updates Due: Once a month

Required Signatures: Client (required if age 14-years or older), Parent (required if child less than 14-years old), program director

Reference: PA Mental Health Bulletin Number OMH-97-19, Date of Issue February 27, 1992;

- FUNCTIONAL FAMILY THERAPY (FFT)

Initial Treatment Plan Due: At the beginning of treatment

Treatment Plan Updates Due: As family completes each phase of treatment, **at minimum every 120 days** (FFT is loaded as BHRS)

Required Signatures: Client, Parent/Legal Guardian, Therapist, Supervisor

Reference: <http://www.episcenter.psu.edu/ebp/familytherapy>

Together with representatives of FFT Inc., the OMHSAS Children's Bureau developed two templates for Pennsylvania M.A-compliant FFT treatment plans. In Template 1 the entire plan is written at the beginning of treatment, while in Template 2 the plan is updated with each phase of FFT. A completed sample treatment plan highlights what OMHSAS expects with regard to content.

FFT is organized around five phases of treatment, each with specific assessment and intervention components that are tailored to the unique characteristics of each family. Early in treatment, the emphasis is on engaging family members and motivating them to participate in therapy. The therapist then conducts an assessment of the family, which is used to guide interventions for behavior change. Interventions focus on changing patterns of family interaction that are maintaining the problem behavior and often include psychoeducation, parent training, and skills training (e.g., communication, problem solving, conflict resolution skills). Once change has occurred within the family with respect to the presenting problems, the therapist helps the family generalize their new skills to other problems within the family and to situations outside of the home, such as problems that may be occurring at school. The therapist also helps the family develop supports and resources to promote lasting change.

SUBSTANCE ABUSE SERVICES

MEDICALLY MANAGED DRUG AND ALCOHOL TREATMENT (4B & 4C)

Initial Treatment Plan Due: Not specified

Treatment Plan Updates Due: Treatment and rehabilitation plans shall be reviewed and updated at least every 15 days.

Required Signatures: Client; the treatment plan updates should be signed and dated by the primary counselor and it is recommended that it be countersigned and dated by the supervisory counselor.

Reference *Legal Reference 55 PA Code § 709.52 (b).*

PA Code TITLE 28 HEALTH AND SAFETY; CHAPTER 157.

DRUG AND ALCOHOL SERVICES INPATIENT HOSPITAL ACTIVITIES—TREATMENT AND REHABILITATION

55 PA Code § 157.42.

TREATMENT AND REHABILITATION SERVICES. REHAB – LONG & SHORT TERM (HOSPITAL)

55 PA Code § 157.22.

PATIENT MANAGEMENT SERVICES:

- (A) There shall be a written plan that delineates specific service planning and counseling approaches used to promote patient interest in participating in necessary treatment following the detoxification process.

55 PA Code § 157.42.

TREATMENT AND REHABILITATION SERVICES:

- (A) An individual treatment and rehabilitation plan shall be developed with each patient. This plan shall include, but not be limited to, written documentation of the following:
1. Short and long-term goals for treatment as formulated by both staff and patient.

2. Type and frequency of treatment and rehabilitation services.
3. Proposed type of support services.
4. Treatment and rehabilitation plans shall be reviewed and updated at least every 15 days.
5. Treatment services shall be provided on a regular and scheduled basis in accordance with the individual treatment and rehabilitation plan.

<http://www.pacode.com/secure/data/028/chapter157/chap157toc.html>

MEDICALLY MONITORED DRUG AND ALCOHOL DETOXIFICATION (3A)

MEDICALLY MANAGED DRUG AND ALCOHOL DETOXIFICATION (4A)

Initial Treatment Plan Due : Not specified

55 PA Code § 157.22.

PATIENT MANAGEMENT SERVICES:

- (A) There shall be a written plan that delineates specific service planning and counseling approaches used to promote patient interest in participating in necessary treatment following the detoxification process

Treatment Plan Updates Due: Ongoing clinical documentation to reflect discharge planning

Required Signatures:

Reference: reference specifically for 4A, CBH applies to 3A as well

<http://www.pacode.com/secure/data/028/chapter157/chap157toc.html>

55 PA Code § 157.21.

ADMISSION—DETOXIFICATION:

- (A) Admission procedures other than initial medical or psychiatric care shall be performed at a time when the patient is mentally and physically capable of comprehension and response.

- (B) Admission procedures shall include documentation of the following:

1. Histories, which include the following:
 - i. Medical history.
 - ii. Drug or alcohol history, or both.
 - iii. Personal history.
2. Consent to treatment.
3. Physical examination.
4. Psychosocial evaluation.

MEDICALLY MONITORED DRUG AND ALCOHOL TREATMENT (3B & 3C)
- SHORT-TERM REHABILITATION

Initial Treatment Plan Due: Treatment plan and biopsychosocial assessment are due by the 10th day of participation in the program (Reference BHS Policies & Procedures 12/5/96 p.14)

Treatment Plan Updates Due: For those projects whose client treatment regime is less than 30 days, the treatment and rehabilitation plan, review and update shall occur at least every 15 days

Required Signatures: Counselor and client at minimum – recommend all involved in the direct care of the client

Reference

Commonwealth of Pennsylvania — Department of Health —Chapter 709, Subchapter E. Standards for Inpatient Nonhospital Activities – Treatment and Rehabilitation — 4/86, 4/03

55 PA Code § 709.52.

TREATMENT AND REHABILITATION SERVICES:

- (A) An individual treatment and rehabilitation plan shall be developed with a client. This plan shall include, but not be limited to, written documentation of:
1. Short and long-term goals for treatment as formulated by both staff and client.
 2. Goals should be realistic and stated in terms of measurable criteria.
 - i. Type and frequency of treatment and rehabilitation services.
 - a. Examples – group counseling twice a week, family therapy every three weeks, bio-feedback bi-weekly.
 3. Proposed type of support service.
 - i. These services may include medical, psychiatric or psychological services, economic, legal, AA, NA, etc.
- (B) Treatment and rehabilitation plans shall be reviewed and updated at least every 30 days.
1. For those projects whose client treatment regime is less than 30 days, the treatment and rehabilitation plan, review and update shall occur at least every 15 days.
 2. The treatment plan update should include an assessment of the client's progress in relationship to the stated goals of the comprehensive treatment plan. The following issues should be considered:
 - i. Have problems or issues that have been identified in the comprehensive treatment plan been impacted upon through treatment?
 - ii. Do the goals need to be revised or restated?
 - iii. Do the treatment strategies or action steps need to be modified?
 - iv. Is closure reflected when goals have been achieved?
 3. The treatment plan updates should be signed and dated by the primary counselor and it is recommended that it be countersigned and dated by the supervisory counselor.

- LONG-TERM REHABILITATION

Initial Treatment Plan Due: Not specified

Treatment Plan Updates Due: Treatment and rehabilitation plans shall be reviewed and updated at least every 30 days. For those projects whose client treatment regime is less than 30 days, the treatment and rehabilitation plan, review and update shall occur at least every 15 days.

Required Signatures: Client; The treatment plan updates should be signed and dated by the primary counselor and it is recommended that it be countersigned and dated by the supervisory counselor.

Reference

Commonwealth of Pennsylvania — Department of Health — Chapter 709, Subchapter E. Standards for Inpatient Nonhospital Activities – Treatment and Rehabilitation — 4/86, 4/03

55 PA Code § 709.52.

TREATMENT AND REHABILITATION SERVICES:

- (A) An individual treatment and rehabilitation plan shall be developed with a client. This plan shall include, but not be limited to, written documentation of:
 - 1. Short and long-term goals for treatment as formulated by both staff and client.
 - i. Goals should be realistic and stated in terms of measurable criteria.
 - 2. Type and frequency of treatment and rehabilitation services.
 - i. Examples – group counseling twice a week, family therapy every three weeks, bio-feedback bi-weekly.
 - 3. Proposed type of support service.
 - i. These services may include medical, psychiatric or psychological services, economic, legal, AA, NA, etc.
- (B) Treatment and rehabilitation plans shall be reviewed and updated at least every 30 days.
 - 1. For those projects whose client treatment regime is less than 30 days, the treatment and rehabilitation plan, review and update shall occur at least every 15 days.
 - 2. The treatment plan update should include an assessment of the client's progress in relationship to the stated goals of the comprehensive treatment plan. The following issues should be considered:
 - i. Have problems or issues that have been identified in the comprehensive treatment plan been impacted upon through treatment?
 - ii. Do the goals need to be revised or restated?
 - iii. Do the treatment strategies or action steps need to be modified?
 - iv. Is closure reflected when goals have been achieved?
- (C) The treatment plan updates should be signed and dated by the primary counselor and it is recommended that it be countersigned and dated by the supervisory counselor.

- HALFWAY HOUSE (2B)

Initial Treatment Plan Due: By the 10th day

Treatment Plan Updates Due: Every 25 days

Required Signatures: Client, Counselor, Clinical Supervisor/Director

Reference: BHS Policies and Procedures (12/5/96) Page 13

OUTPATIENT D&A

Initial Treatment Plan Due: Within 15 days following intake, the clinic's supervisory physician shall review and verify each patient's level of care assessment, psychosocial evaluation and initial treatment plan prior to the provision of any treatment beyond the 15th day following intake.

Treatment Plan Updates Due: Sixty days following the date of the initial treatment plan and at the end of every 60-day period during the duration of treatment, the clinic's supervisory physician shall review and update each patient's treatment plan.

Required Signatures: Each review and update shall be dated, documented and signed in the patient's record by the clinic's supervisory physician.

Reference

55 PA Code § 1223.52.

PAYMENT CONDITIONS FOR VARIOUS SERVICES:

- (A) With the exception of methadone maintenance clinic services, a DAAP shall perform a level of care assessment for each patient prior to admission to the clinic and the provision of services.
 - 1. Within 15 days following intake, the clinic's supervisory physician shall review and verify each patient's level of care assessment, psychosocial evaluation and initial treatment plan prior to the provision of any treatment beyond the 15th day following intake.
 - i. The clinic's supervisory physician shall verify the patient's diagnosis.
 - ii. The clinic's supervisory physician shall sign and date the patient's level of care assessment, psychosocial evaluation, treatment plan and diagnosis in the patient's record.
 - iii. Payment will not be made for services provided within or beyond the 15th day following intake, without the clinic's supervisory physician's review and approval of the level of care assessment, psychosocial evaluation, treatment plan and determination of the patient's diagnosis.
 - 2. Sixty days following the date of the initial treatment plan and at the end of every 60-day period during the duration of treatment, the clinic's supervisory physician shall review and update each

patient's treatment plan. Each review and update shall be dated, documented and signed in the patient's record by the clinic's supervisory physician.

3. The treatment plan and updates shall be based upon the psychosocial evaluation and diagnoses.
 - i. Treatment shall be provided in accordance with the treatment plan and updates and under the supervision and direction of the clinic's supervisory physician.
 - ii. Clinic supervisory physician reviews and reevaluations of diagnoses, treatment plans and updates shall be done in the clinic.
4. A physician may perform a comprehensive medical examination or psychiatric evaluation, when medically necessary, as indicated by either the level of care assessment or the clinic's supervisory physician's review.

IOP

Initial Treatment Plan Due: Not specified

Treatment Plan Updates Due: 60 days

Required Signatures: Primary Counselor and client at minimum, recommend all involved in the direct care of client participate and sign plans.

METHADONE

Initial Treatment Plan Due: Following intake and prior to the provision of any services, the clinic's supervisory physician shall perform a comprehensive medical examination on each patient to determine the patient's diagnoses, initial treatment plan and identify any medical conditions.

Treatment Plan Updates Due: Sixty days following the date of the initial treatment plan and at the end of every 60-day period during the duration of treatment, the clinic's supervisory physician shall review and update each patient's treatment plan.

Required Signatures: Physician or counselor, Client. Recommend all involved in the direct care of client participate and sign plans.

Reference

55 PA Code § 1223.52

- (A) For methadone maintenance clinics, following intake and prior to the provision of any services, the clinic's supervisory physician shall perform a comprehensive medical examination on each patient to determine the patient's diagnoses, initial treatment plan and identify any medical conditions. The clinic's supervisory physician shall document and sign the comprehensive medical examination and treatment plan in the patient's record. The treatment plan shall be developed, maintained and periodically reviewed in accordance with the following criteria:

1. Sixty days following the date of the initial treatment plan and at the end of every 60-day period during the duration of treatment, the clinic's supervisory physician shall review and update each patient's treatment plan. Each review and update shall be dated, documented and signed in the patient's record by the clinic's supervisory physician.

2. The treatment plan and updates shall be based upon the comprehensive medical examination, psychosocial evaluation and diagnoses. Treatment shall be provided in accordance with the treatment plan and updates and under the supervision and direction of the clinic's supervisory physician. Clinic supervisory physician reviews and reevaluations of diagnoses, treatment plans and updates shall be done in the clinic.

32 Pa.B. 5638 55 PA Code § 715.23.

PATIENT RECORDS:

- (A) A narcotic treatment program shall prepare a treatment plan that outlines realistic short and long-term treatment goals which are mutually acceptable to the patient and the narcotic treatment program.
 1. The treatment plan shall identify the behavioral tasks a patient shall perform to complete each short-term goal.
 2. The narcotic treatment physician or the patient's counselor shall review, reevaluate, modify and update each patient's treatment plan as required by Chapters 157, 709 and 711 (relating to drug and alcohol services general provisions; standards for licensure of freestanding treatment activities; and standards for certification of treatment activities which are a part of a health care facility).