



599.10 Treatment planning.

(a) Treatment planning is an ongoing process of assessing the mental health status and needs of the individual, establishing his or her treatment and rehabilitative goals, and determining what services may be provided by the clinic to assist the individual in accomplishing these goals. The treatment planning process includes, where appropriate, a means for determining when the individual's goals have been met to the extent possible in the context of the program, and planning for the appropriate discharge of the individual from the clinic. The treatment planning process is a means of reviewing and adjusting the services necessary to assist the individual in reaching the point where he or she can pursue life goals such as employment or education, without impediment resulting from his or her illness.

(b) For recipients who are Medicaid Fee-for-service beneficiaries, the initial treatment plan shall be completed not later than 30 days after admission. For any other payer or plan, initial treatment plans shall be completed pursuant to such other payer or plan's requirement as shall apply.

~~(b)~~ (c) The treatment plan shall include identification and documentation of the following:

(1) the recipient's designated mental illness diagnosis or a notation that the diagnosis may be found in a specific assessment document in the recipient's case record;

(2) the recipient's needs and strengths;

(3) the recipient's treatment and rehabilitative goals and objectives ~~and the specific services necessary to accomplish those goals and objectives, as well as their projected frequency and duration;~~

(4) the name and title of the recipient's primary clinician in the program, and identification of the types of personnel who will be furnishing services; ~~and~~

~~(5) criteria for determining when the recipient should be discharged from the program; the recommended and agreed upon clinic treatment service and the projected frequency and duration for each service;~~

(6) where applicable, documentation of the need for the provision of off-site services, special linguistic arrangements, or determination of homebound status; and

~~(e7) the signature of the treating clinician, as appropriate. The treatment plan for recipients receiving services reimbursed by Medicaid on a fee-for-service basis shall be signed by a psychiatrist or other physician, and shall include a projected schedule for service delivery and the projected frequency and duration of each type of planned therapeutic session or encounter. For recipients who are Medicaid Fee-for-service beneficiaries, treatment plans shall be signed by a psychiatrist or other physician. For all other payers or plans, treatment plans containing prescribed medications shall be signed by a psychiatrist, other physician or nurse practitioner in psychiatry and treatment plans which do not contain prescribed medications shall be signed by a psychiatrist, other physician, licensed psychologist, nurse practitioner in psychiatry, licensed clinical social worker, or other licensed practitioner to the extent permitted by such other payer or plan's requirements.~~

(d) Treatment plans shall be reviewed no less frequently than annually based on the date of admission or additionally as determined by the recipient's treating clinician. Treatment plan reviews shall include

the input of relevant staff, as well as the recipient, family members and collaterals, as appropriate. The Treatment Plan Review may be documented in progress notes and shall include the following:

(1) assessment of the progress of the recipient in regard to the mutually agreed upon goals in the treatment plan;

(2) adjustment of goals and treatment objectives, time periods for achievement, intervention strategies or initiation of discharge planning, as appropriate; and

(3) determination of continued homebound status, where appropriate.

(e) Treatment plans shall be updated when new services are added, service intensity is increased or as necessary as determined by the recipient's treating clinician. When the treatment plan is updated the treating clinician as appropriate, pursuant to paragraph (7) of subdivision (c) of this section, shall sign the updated treatment plan. All other changes to information in the treatment plan shall only require the treating clinician's signature and may be recorded in progress notes.

(f) Recipient participation in the treatment planning process, including initial treatment planning and treatment plan reviews, shall be documented by notation in the record of the participation of the recipient or of the person who has legal authority to consent to health care on behalf of the recipient, or, in the case of a child, of a parent, guardian, or other person who has legal authority to consent to health care on behalf of the child, as well as the child, where appropriate. The recipient's family and/or collaterals may participate as appropriate in the development of the treatment plan. Collaterals participating in the development of the treatment plan shall be specifically identified in the plan. Recipient participation in treatment planning shall be documented by the signature of the recipient or the signature of the person who has legal authority to consent to health care on behalf of the recipient, or, in the case of a child, the signature of a parent, guardian, or other person who has legal authority to consent to health care on behalf of the child, as well as the child, where appropriate, provided, however, that the lack of such signature shall not constitute noncompliance with this requirement if the reasons for non-participation by the recipient are documented in the treatment plan. The recipient's family and/or collaterals may participate as appropriate in the development of the treatment plan. Collaterals participating in the development of the treatment plan shall be specifically identified in the plan.

(g) Treatment plans shall be completed not later than 30 days after admission, or for services provided to a recipient enrolled in a managed care plan which is certified by the Commissioner of the Department of Health or commercial insurance plan which is certified or approved by the Superintendent of the Insurance Department, pursuant to such other plan's requirement as shall apply

(h) The treatment plan shall include, where applicable, documentation of the need for the provision of off-site services, special linguistic arrangements, or determination of homebound status.

(i) Treatment plans shall be reviewed and updated as necessary based upon the recipient's progress, changes in circumstances, the effectiveness of services, or other appropriate considerations. Such reviews shall occur no less frequently than every 90 days, or the next provided service, whichever shall be later. For services provided to a recipient enrolled in a managed care plan which is certified by the Commissioner of the Department of Health or commercial insurance plan which is certified or approved by the Superintendent of the Insurance Department, treatment plans may be reviewed pursuant to such

~~other plan requirement as shall apply. Treatment plan reviews shall include the input of relevant staff, as well as the recipient, family members and collaterals, as appropriate.~~

~~(j) The periodic review of the treatment plan shall include the following:~~

~~(1) assessment of the progress of the recipient in regard to the mutually agreed upon goals in the treatment plan;~~

~~(2) adjustment of goals and treatment objectives, time periods for achievement, intervention strategies or initiation of discharge planning, as appropriate;~~

~~(3) determination of continued homebound status, where appropriate; and~~

~~(4) for recipients receiving services reimbursed by Medicaid on a fee for service basis, the signature of the physician. For recipients receiving services that are not reimbursed by Medicaid on a fee for service basis, the signature of the physician, licensed psychologist, LCSW, or other licensed individual within his/her scope of practice involved in the treatment.~~

~~(k) (g) Progress notes shall be recorded by the clinical staff member(s) who provided services to the recipient upon each occasion of service. These notes must summarize the service(s) provided, update the recipient's progress toward his or her goals, and include any recommended changes to the elements of the recipient's treatment plan. The progress notes shall also document the date and duration of each service provided, the location where the service was provided, whether collaterals were seen, and the name and title of the staff member providing each service. The need for complex care management and the actions taken by the clinic in response to this need shall also be recorded in the progress notes.~~