Alert #3 05052015  HC AD, HC AL, HC BL, HC BK, HC CH, HC CM P, HC ER, HC LC, HC NC, HC NE, HC YO

**Treatment Plan Definitions**

Community Care supports the principle that comprehensive Treatment Planning is an important part of the therapeutic process. All levels of care specify Treatment Planning/Treatment Plans as a requirement, but some do not have a regulation-defined outline of the required elements of a treatment plan. The goal of this Provider Alert is to define Community Care’s expectation of a Treatment Plan for those levels of care for which there is no regulatory guidance available.

This Provider Alert is applicable to services provided by physicians, psychologists, social workers, professional counselors, and other contracted provider types who are working in private practice and who are licensed as individual practitioners with the Department of Human Services in the Commonwealth. This Provider Alert also applies to any level of care in which Treatment Planning is required or any level of care in which traditional outpatient services (defined as Individual Therapy, Group Therapy, or Family Therapy) is delivered.

If you are providing a level of care that does not already have a specific treatment plan process and structure outlined, your treatment plan must conform to the standards below which are based on 55 PA Code 5200.31:

A qualified mental health professional or treatment planning team shall prepare an individual comprehensive treatment plan for every patient. Treatment plans must:

1. Be documented separately from the clinical notes.
2. Be based on the results of the diagnostic evaluation.
3. Be developed within 15 days of intake, be reviewed and updated every 120 days or 15 patient visits—whichever is first. Written documentation of this review in the case record is required.
4. 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.
5. Include discharge goals and discharge disposition.
6. Be referenced in the progress notes written after each session is completed.
7. Be directed at specific outcomes and connect these outcomes with the modalities and activities proposed.
8. Be formulated with the involvement of the person receiving services, including having his/her signature on the Treatment Plan (signatures of others involved in the treatment plan should also be included (i.e. Mental Health Professional...
writing the Treatment Plan and any other team members involved in the treatment plan).

a. 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.

9. 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.

It is our expectation that the above standards are followed ASAP. Please note that these will be the standards used for any Quality or FWA review moving forward. **It is our expectation that you follow these guidelines for all members in treatment as of June 1, 2015.** Failure to adhere to these treatment plan requirements may result in retraction of claims, requirement to implement a corrective action, or other sanction.