Treatment Plan Documentation
Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)

**Scope:** This Provider Alert applies to all HealthChoices contracted federally qualified health centers (FQHC) and rural health clinics (RHC) who are required to document treatment plans for services delivered to Community Care members (“Members”).

Effective November 1, 2017, this alert serves to provide specific clarification regarding treatment plan documentation for FQHCs and RHCs and supersedes information contained within Provider Alert #3 (05/05/2015) Treatment Plan Definitions specific to these provider types.

These standards are based, in part, on 055 Pa. Code § 1101.51 (general provisions), Community Care Performance Standards, Fraud, Waste & Abuse policies & procedures, Quality Management standards, the Community Care Provider Manual, and the PA PROMISE Provider Handbook, including Appendix E - FQHC/RHC.

**PA PROMISE Provider Handbook, including Appendix E - FQHC/RHC**
Charts/Records: The FQHC/RHC must maintain legible, accurate, and complete charts and records in order to support and justify the services provided (Chapter 1101.51). Chart means a compendium of medical records on an individual Member. Record means those dated reports corresponding to office, home, nursing facility, hospital, outpatient, inpatient, and any other place of service supporting claims submitted to the Pennsylvania Medical Assistance Program.

Records of service shall be entered in chronological order by the specific practitioner who rendered the service. For reimbursement purposes, such medical and behavioral records shall be legible and shall include but not be limited to:

1. Dates of Service
2. Member’s name and date of birth
3. Name and title of the licensed provider performing the service
4. Chief complaint/justification or reason for the visit
5. Pertinent medical history
6. Pertinent findings on examination, including length of time spent with the Member (if a group session, the number of individuals in the group, should be noted)
7. Medications and/or equipment/supplies delivered or prescribed
8. Description of treatment (when applicable)
9. Recommendations for additional treatments, procedures, or consultations
10. Tests and results, if any (applicable to physical health or behavioral health, e.g. behavioral health measures, PHQ-9, etc.)
11. Plan of treatment/care/outcome
Each note must reflect the above documentation requirements. Additionally, Community Care requires the following information and process to be incorporated in the development of the Plan of treatment/care/outcome:

1. The treatment plan must be clearly identified and labeled within the encounter note. It does not need to be a separate document.

2. The treatment team or individual practitioner prepares the written treatment plan for each Member based on his/her needs and strengths, physical and behavior health history, assessment findings and diagnosis.
   a. The plan must be consistent with areas of need identified in the Member’s assessment
   b. The plan must include documentation reflecting all team members involved in the behavioral health treatment of the Member (e.g. physician, licensed independent practitioner, etc.).

3. The treatment plan must be developed and reviewed with the Member, at the point of assessment and updated with the Member on each behavioral health visit.
   a. The plan must show clear evidence of individual involvement of the Member, guardian, and PCP, as required in the initial development and update of the plan.

4. The treatment plan must contain actionable/functional treatment goal(s) based on that which the Member identifies as meaningful to them. The plan:
   a. Documents planned intervention(s) and their frequency, specifying action steps to take to reach goals. Interventions may include brief problem-solving sessions, chronic disease management groups, etc.
   b. Identifies the clinician responsible for carrying out interventions
   c. Documents Member outcomes/goal attainment in response to specific interventions
   d. Contains recommendations from the behavioral health clinician to the primary care provider (PCP)
   e. Includes the date for follow-up with the behavioral health clinician, when applicable
   f. Documents referrals when made to community mental health centers, substance use disorder providers, or others (Specify)

5. Each progress note must contain the plan, including the goal(s) and updates in order to submit a claim for payment for the service delivered.
6. The treatment plan is developed and reviewed, per state and federal regulatory guidance, including provider-type licensing regulations and confidentiality and privacy rules and regulations.

7. The treatment plan does not require physician signature when an independent practitioner, other than the physician, is providing treatment or services to the Member unless regulation or bulletin indicates otherwise.