Treatment Plans
Treatment Plans

- Required with 15 business days of the first face-to-face contact with the beneficiary/legally responsible person (LRP)
- Must be developed based on the Comprehensive Clinical Assessment
- Must be developed in partnership with the consumer and/or LRP

(reference Clinical Coverage Policy 8C 7.3.4 Individualized Plan)
Basic Items to Consider

• All new or updated treatment plans require signatures from beneficiary/LRP AND licensed professional and must be dated to authenticate the plan

• If LRP is someone other than the parent (i.e. DSS), provider must obtain a copy of the custody papers and retain in the service record to verify agency’s authority to act on individual’s behalf

• Treatment plan must be an identifiable document in the service record
Basic Items to Consider

• There is a basic treatment plan for OPT services, but some choose to use the enhanced Person Centered Plan (PCP)
  o If this version is used, it must be fully completed and meet all requirements of a PCP including Comprehensive Crisis Prevention and Intervention Plan (see APSM 45-2 Chapter 4 for guidelines on developing a PCP)

• Evaluation and Management (E/M codes) Services do not require a treatment plan
Person Centered Plan

• Person-centered thinking is a guiding principle that must be embraced by all involved in the MH/IDD/SU service delivery system

• Especially true when developing service (treatment) plans

• Person-centered thinking provides a way of connecting to the individual who is requesting services in order to lay a person-driven foundation for individualized care

(reference APSM 45-2 chapter 4)
Person Centered Plan

• While some services PCP format, others may utilize another service plan format

• Regardless of format used, person-centered thinking and individualized service planning are hallmarks of the provision of high quality services in meeting the unique needs of each person

(reference APSM 45-2 chapter 4)
Person Centered Plan

• Each plan driven by the individual, utilizing the results and recommendations of a comprehensive clinical assessment, and is individually tailored to the preferences, strengths and needs of the person seeking services

(reference APSM 45-2 chapter 4)
Required in the Treatment Plan

• Beneficiary outcomes anticipated to be achieved by provision of the service and projected date of achievement (target date)

• Strategies and interventions that will assist the beneficiary with meeting his/her goals

• Staff responsible for implementing the strategies and interventions
Required in the Treatment Plan

- Schedule for review of the plan (in consultation with the beneficiary/LRP or both) as needed, but at least annually to review goals and strategies to promote effective treatment, with target dates not to exceed 12 months.

- Basis for evaluation or assessment of outcome achievement.

- Written consent or agreement by the beneficiary/LRP, or written statement by the provider stating why such consent could not be obtained.
# Treatment Plan Samples

(from LIP Resource Packet)

<table>
<thead>
<tr>
<th>Consumer</th>
<th>Record Number</th>
<th>Date:</th>
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<tbody>
<tr>
<td>Goal</td>
<td>Service(s)/Modalities/Intervention (including frequency and duration)</td>
<td>Responsible Person/Position</td>
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**Staff and Consumer/Legally Responsible Person sign below whenever the plan is implemented/reviewed/revised.**

<table>
<thead>
<tr>
<th>Date</th>
<th>Staff Signature</th>
<th>Date</th>
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**Status Codes:**
- Re Revised
- On Ongoing
- All Achieved
- De Discontinued

(Inc.)
Updates to Treatment Plans

• Review and review treatment plans when:
  o Needs of the person have changed, additional goals needed, goals are met, changes in strategies/interventions
  o On or before target dates expire
    • Plans must be updated annually
    • Any plan not updated by the one year anniversary considered out of compliance
  o Service or provider change
    • If there is a change in therapist the plan will need to be updated to reflect this
Adolescents/Children in SA Treatment

• Must include signatures from both the staff and the adolescent/child

• May be implemented without parental consent with services provided under the direction/supervision of a physician
  - If services NOT under the direction/supervision of a physician, LRP signature is required

• Any minor child who is emancipated may consent to any medical treatment or dental and health services
References

- NC DMA Clinical Coverage Policy 8C 7.3.4
- 10A NCAC 27G .0205 (d)
- APSM 45-2 Chapter 4
- N.C.G.S. § 90-21.5 (specific to children and adolescents)