TREATMENT PLANNING, REVIEW AND MODIFICATION (Update 07/26/2017)

1. We are in the process of implementing a self-report survey tool that would greatly improve our ability to obtain up-to-date clinical information to guide our clinical interventions, monitor clinical change over time, and assist client and worker with feedback for treatment planning. The automated feedback on the client's current issues/needs will be received within minutes of completion of the survey, can be reviewed in 3-5 minutes, and will improve our ability to deliver services tailored to the client's stated needs. How would we document this service to be compensated for it? Can the two functions: client independently filling out the survey and clinician reviewing the results (with/without the client) be combined and considered an aspect of Treatment Plan Development, Review and Modification?

Answer: As described, this is not a claimable 132 service. The time spent by the client completing the survey is not the provision of any 132 service by staff. And, as you have described the staff review, it does not take sufficiently long to be billable.

2. Rule 132 states: The ITP shall include a definitive diagnosis that has been determined for all five axes… If the diagnosis cannot be determined by the time the ITP is completed or a rule out diagnosis is given, the client's clinical record include the diagnosis determined as a result of additional evaluations recommended in the MHA report within 90 days after completion of the MHA report." In this definition, does DMH consider diagnoses with 'Not Otherwise Specified' to be definitive diagnosis? Or do those diagnoses, for example, Depression NOS, need to be further evaluated within the timeframe stated in the above definition?

Answer: Depression NOS is a definitive diagnosis and needs no further evaluation.

3. Are there outside limits for an estimated discharge date?

Answer: The element is a discharge/transition date and does not infer discharge or discontinuation of all services. Rather, the date should be the target date for consumer transition to a less intensive level of care or discharge date, whichever is applicable.

4. In regard to Recovery Model & Treatment Planning, what happens if none of the consumer's chosen treatment goals are deemed medically necessary?

Answer: Consumer's treatment goals should be focused on their desired recovery process and outcome. It is the role of the mental health professionals to devise action steps that address medically necessary needs. If there are none, the consumer should not be involved in Rule 132 services.

5. What happens if needs identified by the consumer are not identified as needs on any assessments?

Answer: Consumers are to be asked about their goals not in terms of 132 services, but in terms of their life. The services included in the ITP with goals and objectives are to address the needs identified that are standing in their way of achieving their life goals as a result of their mental illness.

6. How do you balance module-based, skills training/evidence-based with non-linear, individualized treatment adapted to meet the client's needs?

Answer: Either approach may be appropriate and beneficial depending on the individual consumer's needs and preferences.

7. We have a question regarding situations where the psychiatrist's diagnosis is different than the one in the completed and signed MHA, and we need to document this change. We are talking about a time frame of weeks to maybe one month following the completion of the MHA. Do we need to document this change in a MHA review, or can it be documented in another way? If we need to document the change in a MHA review, is it sufficient to do an abbreviated MHA review which only addresses the issue of a diagnostic change and not the other MHA elements, as long as we complete a full MHA review within a year of the original MHA?

Answer: A new diagnosis must be reflected in the ITP, not in the MHA.

8. Rule 132 requires a single ITP. We have a few clients in MH & substance abuse services; those 2 programs are very different in terms of what a treatment plan looks like, how services are named, coded, etc. - does this provision refer strictly to MH or all programs? If for all programs, could you give some guidelines on how to address this provision, as each state agency will audit for specific concerns (i.e., DASA auditors would not accept a MH-ITP or vice versa).

Answer: An integrated treatment plan may contain more than one form or section, but should include everything a client is receiving from your agency.

9. Rule 132 requires continuity of care planning, estimated transition or discharge date & goals identified for continuing care. Can this be satisfied by adding narrative notes to the review?

Answer: The rule requirement is for continuity of care planning to be incorporated into 6-mo ITP reviews, not initial ITP development. Documentation must be available for review and be incorporated into the rest of the ITP review.

10. We have a SASS case that opens/closes/reopens in a short period of time. When originally opened, the SASS worker completed the MHA within the 30 days and the ITP shortly afterward. The client did not want to engage in SASS services because she was engaged elsewhere. Although services were refused, as the SASS provider, we are required to be involved during the hospitalization. The only objectives on the ITP are to consult with other treatment providers to coordinate services, i.e., hospital monitoring, discharge planning, etc., and refer/link client to any necessary resources. The SASS worker closed her case about 1 week after completion of the ITP. The client was re-hospitalized requiring the SASS worker to re-open the case less than a month after closure. The worker completed an MHA Update with relevant information due to the crisis. Can the SASS worker use the ITP completed 1-2 months prior, or, does the SASS worker need to draft a new ITP? The ITP goals or objectives are the same with the 2nd re-opening and the client still doesn't want services from SASS.

    Answer: Yes, you must have a new ITP that reflects the current MHA and includes goals/objectives developed to engage the client in services in order to stop the crisis cycle.

11. A treatment plan was completed in March 2007. The 6-month review was due in September 2007, but was done in July 2007. The next treatment plan is due in January 2008, not March 2008, because it is 6 months after the last (July 2007) review. Is this correct?

Answer: You are correct.

12. When clients are too sick to sign treatment plans, can we note "not clinically indicated?" For instance, a client is paranoid and does not want to sign a treatment plan.

Answer: Stating "not clinically indicated" without further explanation is not sufficient. It is important to document how the client is going to participate in services when they're at this level of illness and what you've done to explain to them what is going on and what the purpose of the treatment plan is. It would also be helpful for us to be able to see what you've done to obtain their involvement in the planning process to reduce their paranoia.

13. I'm looking for clarification on a standard in Rule 132 which states: "If services are provided prior to completion of the ITP, and the client terminates services before the ITP is completed

and signed, the provider must complete the ITP and document that the client terminated services and was unavailable to sign." 59 IAC 132.148(c)(11)(B) Is a completed ITP required for preliminary services authorized by an LPHA if the client drops out before development of a formal ITP?

Answer. There must be an ITP in place that meets all requirements for an ITP as stated in Rule 132 for services to be billed. An ITP that is not signed by the client is sufficient if it includes everything required in the Rule for a treatment plan and has an explanation of why there is no consumer signature. After the completion of a mental health assessment report, any service noted on that report may be provided if the service subsequently appears on the ITP. Therefore, if services are terminated after the MHA report and prior to completion of the ITP and the ITP is not completed, services during that period of time may not be billed.

14. I am requesting some clarification on the signing of the ITP. How would you handle the situation where the plan may be outdated as of April 2, 2008 and the client is scheduled for an appointment on April 20, 2008? Would you develop a plan without client input and have the LPHA sign? Can we wait and develop the plan when the client is present on the 20th? I know we are not to bill for any services without a plan in place and authorized, so we can assume this client will not have any service provision between the 2nd and the 20th.

Answer: It is important to plan ahead and be soliciting client input all along and not just on the day that the ITP is reviewed. This input can then be incorporated without the physical presence of the client on a specific date. The effective date of the ITP is the date that the LPHA signs it.

15. I have a treatment plan completed on January 1 but not reviewed until June 30. What happens to billing? Does it affect billing as of June 1 or January 1? I did a treatment plan on March 5, 2007 and reviewed it on September 5, 2007 but was not able to do another treatment plan until March 30, 2008 - does this affect billing? If so, how much billing does it affect? How far does it go back?

Answer: A treatment plan is effective for six months from the LPHA's dated signature. If not reviewed and signed by the LPHA at the end of the six month period, it is no longer current. Services provided without a current treatment plan are not billable.

16. Will we be cited in an audit if a client's diagnosis does not match between the Doctor's notes and the tx plan? When we do self audits, we always look for this. Many times our Doctors will change or add a dx, but not communicate this to the clinician. Whose signature trumps whose? Is the LPHA signature on the current tx plan what sticks in terms of the dx? Or is it a Doctor's signature on a note that was written when a current tx plan is still valid?

Answer: The treatment plan must reflect the current diagnosis. If there is a note in the record from the qualified professional that has done the most recent assessment to determine a diagnosis, the treatment plan must reflect that diagnosis.

17. The rule regarding ITP states that "the results of crisis assessments, reassessments or additional evaluations after the client's ITP is completed shall be incorporated into a modified ITP, if appropriate, within 30 days." However, the service definition and reimbursement guide states that crisis intervention services are not required on the ITP. Must crisis services be added to the ITP in order to bill for crisis intervention?

Answer: Crisis services are not required to be in any ITP. The standard means that, if service needs change based upon a crisis, those changed needs should be reflected in the ITP.

18. We interpret the continuity of care goal to relate to one of the following: discharge from services, transfer to a new service or discontinuation of a service, short-term goal related to recovery, or frequency of a service provided. Does the continuity of care goal have to relate to discharge from services and is the estimated transition or discharge date the estimated date that the client is discharged from MH services? Must a discharge date be included in the ITP?

Answer: The rule does not require a discharge date be included in the ITP. Based on the philosophy of recovery, the intent of the rule is that there be a date in the ITP for estimated transition or discharge. On that date further discussion should take place about the estimated transition or discharge and what may have changed that impacts a transition taking place.

19. Does the 5 Axis diagnosis need to be on the Individual Treatment Plan Review? Rule 132 does not say it does, but in the past we received a compliance citation for not having the diagnosis on the review form. I am creating a new electronic form and would like to have only the required elements to avoid confusion.

Answer: Yes, the full diagnosis must be on the ITP update.

20. Can you start billing for Treatment Plan Development before the Mental Health Assessment is signed by the LPHA?

Answer: No. Per Rule 132, the only services that may be provided prior to completion of the mental health assessment are case management-mental health, psychological evaluation, and crisis services.

21. Does the ITP need to be completed within 45 days of completing the mental health assessment even if the client is not seen again?

Answer: If no services have been initiated as a result of completing the mental health assessment report (MHA), then no treatment plan (ITP) needs to be developed. If mental health services have been initiated after completion of the MHA but before development of the ITP and billing is done, then an ITP must be developed even if the client never comes back to the provider for services. The provider must document why the client did not participate in the treatment planning process.

22. When the Mental Health Assessment is complete but the Individual Treatment Plan is not developed and is not signed off on, do we need to have a stated goal for the services provided? Do we bill for these services as ITP development or some other service?

Answer: Mental health services may be provided upon the completion of the mental health assessment and prior to the completion of the treatment plan, with the expectation that the services provided will be on the treatment plan. Services should be provided based on the client's assessed needs and correspond to goals on the treatment plan. Services must be billed as the service provided. Unless nothing but ITP development, review and modification is provided, other services should also be billed.

23. Does counseling and therapy have to be stated under each goal? For example, a client's mother dies; the clinician provided therapy for the overall mental health goal/well-being of the client, and to stabilize. Does the counseling have to be listed under each goal of the ITP?

Answer: We find it difficult to visualize that there is no goal on the individual's treatment plan that does not tie to stabilizing a client after the death of a parent. Life has both planned and unplanned events but goals such as "learning how to cope with stressors and appropriate responses" can be generalized to a variety of activities. If there is no treatment goal that can be tied to the activity, a treatment plan modification must be completed.

24. We have been doing PSR-UM reviews of agencies who are very high users. In the course of this I noticed that agencies frequently use a 1-year time span for ITP goal reviews, since they update their MHAs yearly. I have encouraged agencies to establish shorter, goal-appropriate time spans for goals. However, this necessitates ongoing goal evaluation. As such, the agencies are asking how to document that. Some have asked if it necessitates a complete or partial MHA review. My inclination is that if there has been a major change in the client's situation or condition, then all that is necessary to document the completion for the goal is a note in the chart or on the ITP indicating that "Mary now knows how to tie her shoes, so she is moving on to the next step of her ADL goal, which is face-washing." Then a new objective with a new time span is established in the ITP without MHA modification. Then they would bill this as ITP development or modification - correct?

Answer: First, ITPs must be reviewed every six months. As described, it seems the ITP already contains progressive goals that would already address the MHA needs and services. Goals may be modified to continue to address the needs identified in the MHA and documented as part of progress. The MHA must be updated when circumstances, needs and services change and may be updated in between annual reviews with an addendum. When a provider provides treatment plan development, review and modification, they may claim for it. However, writing notes (doing paperwork) is not claimable. So, if the provider is only documenting that a client has moved to the next goal/objective in the series, that is not claimable. If the provider has delivered a service to the client related to the shoe-tying and notes this is completed and the client will next begin another goal, then this is claimed as the service that was delivered.

25. Rule 132 indicates that "the ITP review shall include an estimated transition or discharge date and identify goals for continuing care." Does "...identifying goals for continuing care.." mean that client and staff should identify and document goals for treatment post discharge, or, does that language indicate a need to identify goals for continuing of care from the current tx plan? If it means the latter, identifying goals for continuing care from the tx plan under review, can this be done in the form of a progress note? Can the "transition and/or discharge date" be indicated on an ITP review form and the goals explanation be found in our progress notes or do they need to be housed together on the same form in the same place? Can we allow the client to choose the discharge date and/or what that readiness (goal) would look like for the client? If yes, is it OK to have a discharge date that is potentially 6 mos, 1 yr, 2 yrs, or more? What are the implications of each if the goal of that discharge date is not met?

Answer: You are overthinking this. This is intended to focus thoughts on recovery. There does not need to be a specific date indicated for discharge unless there clearly is one. The goals for continuing care are those things that will be necessary to support the client when she/he has moved sufficiently along in recovery to no longer need your services.

26. Are we able to bill Individual therapy or case management prior to having the ITP signed by the "L"? In this particular case, a case manager completed the MHA, which included the need for individual therapy and case management. In addition, the treatment plan was completed on the same day with the consumer. The "L" reviewed and signed the MHA on the same day acting as the "Q" and the "L" but took five days to sign the treatment plan. In between the five days, we have generated billings for individual therapy and case management. How should we proceed with the five days of services provided to the consumer?

Answer: When the MHA is completed (signed by the L), services may begin as long as the services are recommended in the MHA and then become part of the ITP and the ITP is completed within the required time.

27. Is a client (and parent or guardian if applicable) required to sign a treatment plan review document if each review session results in a new treatment plan? Our electronic health record provides a new treatment plan every 6 months, or sooner if needed, that the client signs. We do have an internal document that our clinicians complete to state progress towards goals, etc. We currently have the client sign it but they also have to sign the new treatment plan. A treatment planning session is conducted where a review of the old plan and development of the new plan is done. Since the client signs the new plan, do they also have to sign the review document?

Answer: As long as there is always a new treatment plan that the client signs, the client doesn't also need to sign the review document. If the review document is ever used to modify a treatment plan without a new treatment plan being developed, then the client must sign that document.

28. BALC staff mentioned that we need two client signatures and two staff signatures on the ITP. Our treatment plan includes the statement: "As the provider staff, I attest that process for the development, review, and modification of the contents of this ITP have been explained to

the client and the client's parent/guardian as applicable." The client and staff person sign the ITP. Does this meet the intent of the rule?

Answer: Partly. The statement should say "I attest that I have explained…" and there should also be a statement above the client's signature that attests that they agree that it was explained.

29. Rule 132 states "Treatment plan development, review, and modification is a process that results in a written ITP, developed with the participation of the client and the client's parent/guardian, as applicable, and is based on the mental health assessment report and any additional evaluations." In the past, auditors determined we were in compliance with Rule 132 if we changed service recommendations at the time of the ITP development. In a recent review, we received notification that services would be disallowed because they were not recommended by the assessment (although recommended in the ITP). One suggestion made was to make additional recommendations on the treatment plan and describe why those services were added. Would this approach be sufficient? Is it possible that the LPHA signature on the ITP is sufficient to authorize additional services?

Answer: The mental health assessment report is not required to include specific Part 132 services unless services are provided prior to the development of the ITP and after completion of the MHA report. If they are completed on the same day, there may not be services listed in the MHA report with which to compare the ITP services. The MHA report will be an analysis of assessment findings and direction that medically necessary services will be taking. As long as services continue to be provided to meet an assessed need as documented in the current MHA report, the MHA report and ITP may not include the same services.

30. What type of treatment plan would be appropriate for a client who is not receiving outpatient therapy, but is seeing the psychiatrist for medications? The client is stable on medication, and sees the nurse for case management, i.e., Patient Assistance Program. My concern is that the goal would be the same all the time, and for clients who are being seen for patient assistance, there may not be any new or different objectives to be worked on. Answer: Anyone receiving 132 services must have a MHA and ITP as detailed by Rule 132. If a physician is providing services and billing directly to the Dept. of Healthcare and Family Services, s/he must do so in accordance with the expectations of HFS. 32. Are we correct in our interpretation that a single ITP objective may have more than one service type to support achieving that objective?

Answer: Yes, you are.

31. The total amount of service to be provided may be only the single value shown on the ITP, although it may be repeated on multiple objectives. Can we repeat the occurrence of a single service amount over multiple objectives?

Answer: Yes, you may. Services must be delivered based on assessed needs to achieve the established goals/objectives.

32. In looking at the Service Definition and Reimbursement Guide, one of the example activities to bill for treatment planning is "time spent by the QMHP/MHP reviewing the assessment materials and developing the ITP with others." Would this be applicable for a QMHP/MHP simply reviewing a treatment plan to ensure it meets medical necessity after the plan has been written? In other words, they are doing a quality assurance and compliance check on the plan and wondered if they could bill for this.

Answer: This is considered paperwork and as such is not billable.

33. I have always been a bit uncertain about what exactly is required on an ITP review. Could it be something as simple as listing the goals and objectives and if they were met, not met or need revision? Are the Q and the L the only required signatures? A statement as to whether or not the plan continues to meet the stated goals is needed too, could that be a yes or no check box?

Answer: Checklists as you describe would not be acceptable nor would they be good clinical practice. If no progress was made, then why would need to be discussed and the ITP changed. If progress is being made, then it should be discussed and the ITP changed to reflect. Additionally, the client must also sign the updated ITP.

34. We try to get the ITP going four weeks ahead of the due date and still there are consumers we cannot get connected with until afterwards, due to cancellations and no shows. I thought the answer was: if the provider has made an attempt to contact the consumer for an ITP review and it is documented as such, then the provider should wait until the next time there is contact with the consumer and then together they should go over the ITP review. If I recall correctly, as long as no services other than crisis intervention or case management are provided, then there is no issue regarding the ITP not being completed within the 6 month period. My understanding is that it is about the attempt to connect with the person and then to document why the ITP did not get reviewed within the 6 month deadline.

Answer: ITP review is required every six months. If the client is not in service at the six-month point, a note should be made in the record and a new MHA and ITP must be developed when the client returns to service.

35. Do PSR Group and PSR Individual both need to be listed as a service on the Treatment Plan and billed separately? This question has come up a few times. Community Support Group and Community Support Individual must be listed as separate services. Some agencies list PSR as the intervention/service which is meant to include both individual and group PSR services.

Answer: The following services must be listed on the ITP as group or individual as determined by the client's need and preference: Therapy/Counseling (also family must be specified), Community Support, Community Support - Residential, PSR, Medication Training. ACT does not need to be specified as individual or group.

36. In a limited set of circumstances, we sometimes complete treatment plans over the phone. Obviously, the client cannot sign the treatment plan at that time. According to the "crosswalk," treatment plan review, development, and modification can be completed over the phone. Is it acceptable to have the LPHA sign the treatment plan if there is a progress note stating that the client agrees with the goals and objectives and will sign when they see their care provider?

Answer: Yes, it is.

37. Regarding the ITP review and including continuity of care planning, how and where should this be documented? Can it be a statement on the Treatment Plan itself? If so what type of documentation is required?

Answer: Not only can continuity of care planning be addressed on the ITP, that would be the best place. It should be included in the six month ITP review notes and then necessary changes to the ITP as a result of that review should be reflected in the ITP.

38. If there is a list of recommended services on an MHA, do they ALL have to be addressed in the treatment plan? I have been directing people that they don't have to address every single recommendation at the same time. They may choose to focus on a few services initially and add more later. Is that ok?

Answer: It is ok to have objectives on only some of the recommendations at any one time. However, it must be clear why those were chosen and why others are not being addressed now. So, all recommendations must be addressed, but all don't have to be actively worked on.

39. I believe Rule 132 states "Time spent by the QMHP/MHP reviewing the assessment materials and developing the ITP with others" is billable as Treatment Plan Review and Development. Can staff bill the following as Treatment Plan Review and Development - reviewing clinical documents, IEP's, etc, under the assumption that it could impact the current ITP. If so, would

this sample note be sufficient: Reviewed client's current IEP. Based on this review, client's current treatment plan (does not appear to require further modification) may require further modification as follows: (indicate possible changes to Tx Plan) Will discuss with client at next visit.

Answer: Reading reports is not a billable service. Reviewing and developing with others, per the guidelines, is required.

40. What exactly will you be looking for in audits in regard to the treatment plan and recovery language?

Answer: There is no exact "recovery" language expected in the treatment plan. A recovery model of service delivery cannot be a cookie cutter approach to services. There should be evidence that shows client involvement in services in a way that empowers them. Please refer to the DMH webpage for more on principles of recovery.

41. Are LPHA initials sufficient on changes that need to be made on the ITPs, or must the LPHA fully sign each change made on the ITP?

Answer: The LPHA must sign, not just initial, the ITP each time it is changed.

42. Does the rule require that ITP Review include "Continuity of Care Planning" with the client/parent and an estimated transition or discharge date with goals for continuing care? Would you please define what is meant by "continuity of care planning" and give examples of documentation that would show compliance with the new requirement?

Answer: Continuity of care is a way to get the provider and client working together to achieve recovery. There must be evidence of discussion of an ultimate goal and how, together, that goal will be achieved. It is not expected that there will be a final date of service specified, but there must be documentation of the ongoing discussion of the move toward recovery.

43. When we order a Rule 132 service on the treatment plan, must we specify the mode of delivery (individual, group, telephone, face-to-face, onsite, etc.)?

Answer: Yes. The following services must be listed on the ITP as group or individual as determined by the client's needs and preferences: Therapy/Counseling (also family must be specified), Community Support, Community Support-Residential, PSR, and Medication Training. ACT does not need to be specified as individual or group. Telephone, face-to-face, and on-site/off-site don't have to be specified.

44. Do we need to enter a clinician's name for each service provided, or only the name of the clinician responsible for the overall treatment plan?

Answer: There must be a staff name unless a title points to a single staff. If only one staff is responsible for the delivery of all services, then just one name may be listed. It must be clear that one person is responsible for all services. We do not require the name of each staff that will provide a service, only who is responsible for the delivery of service(s).

45. If an ITP has reached the scheduled review date with the consumer and treatment team, but the consumer cancels or fails the appointment, then calls several days later asking for prescriptions to be renewed, can the agency bill for case management services when they call in the scripts if everyone on the team except the consumer has signed off on the ITP?

Answer: The ITP must be current before providing services, and goes into effect at the time of the L's signature. Obtain the consumer's signature at the next face-to-face meeting.

46. On the ITP, can we write the name of the specific Rule 132 service to be provided (PSR, community support individual, etc.,) and not include the service code?

Answer: Yes, as long as you are specific regarding group and individual.

47. Is it necessary to get client and LPHA signatures if objectives or specific interventions in a treatment plan are added or changed?

Answer: All changes to the ITP must be indicated on the ITP and have the dated signature of the Q, L, and client/guardian.

48. Is there a requirement that the ITP be completely re-written annually, and if so, what is the citation?

Answer: No, however, the rule states that the L and Q shall review the ITP no less than once every 6 months and that the ITP shall be modified if it is determined that there has been no measurable reduction of disability or restoration of functional level. The entire ITP should be reviewed each time and the documentation should show that. Additionally, the rule states that the ITP and all its revisions shall be signed by the parent/guardian as appropriate and the client.

49. Does each 132 service for an objective have to list the amount, frequency and duration, or would an effective and target date for the objective meet the duration requirement? Example: Objective-John will identify triggers that lead to his inappropriate expression of anger and learn 3 coping mechanisms to be able to respond better. Effective Date-07/30/08 Target Date-09/30/08. Service Prescription-Individual Therapy-1 hour weekly; Client Centered Consultation-.5 monthly; Individual Community Support-2 hours monthly.

Answer: Your example is acceptable.

50. Please define and provide specific examples of the following terms: frequency, amount and duration.

Answer: Frequency is how often the specified service will be provided, e.g., 3x/Wk; Amount is how much time will be spent doing the specified service during each session, e.g., 45 min.; Duration is how long the specified service will be provided, e.g., 6 mos.

51. In terms of frequency, is it still ok to use phrases like "as needed" and if not, could you suggest another phrase that would be acceptable?

Answer: "As needed" is not acceptable. Acceptable examples include: "3 times per week" and "twice per month." Estimate to the best of your ability how often a service will be provided. As experience indicates, adjust the frequency to better reflect what is delivered.

52. We are attempting to have the client identify a client goal for each service provided. It was my understanding that client goal(s) should be identified and listed in the treatment plan, however, several services might contribute toward meeting that goal. We want to make sure we do not need to have a client stated goal for each service.

Answer: All goals should be client goals and are integral to services. We anticipate that there will be more than one goal for each service. More typically, there is more than one service per goal. The consumer has something that they and the provider want to accomplish and it will take more than one service to do it. They should always start with what is to be accomplished and decide what service(s) will help them do that. There does not have to be 1:1 correlation.

53. Can services such as case management - client centered consultation, psychological evaluation, etc., be included as a standard/canned objective (written the same way for each person that needs the service) for consumers who are determined to need them?

Answer: Objectives absolutely need to be individualized. It is understandable that there are only so many ways to write an objective but it should be personalized to the needs of the individual.

54. Please describe what is meant by "continuity of care planning" in Treatment planning.

Answer: The continuity of care goal relates to one of the following: discharge from services, transfer to a new service or discontinuation of a service, short-term goal related to recovery, or frequency of a service provided. The expectation is recovery, and the treatment must include efforts toward reaching that goal.

55. As long as there is some narrative, can the rule requirement of, "Written documentation describing the interaction that occurred during service delivery, including the client's response to the clinical interventions and progress toward attainment of the goals in the ITP" be satisfied with check-boxes such as: ?Responded positively to clinical intervention; ?Actively working on treatment goals; ?Not working on treatment goals?

Answer: As prompts, those are satisfactory, but there will need to be strong supportive narrative. We fear that staff would not support them well. As a stand-alone, they are not acceptable documentation.

56. My understanding is that an ITP becomes effective on the date that the LPHA signs it. If a client cannot sign it on the same date as the LPHA, may s/he sign it on a different date? For example: client is scheduled for ITP review on January 5th, but misses the session due to illness. Can the LPHA sign the ITP on January 5th, then review it with the client and ask him/her to sign it during the next appointment on January 12th? If so, are services rendered from January 5th through January 11th billable?

Answer: Far more important than just getting the client's signature on the ITP, is that the record demonstrate the client's active involvement in their treatment and the planning for it. Therefore, while the date of the LPHA signature is the effective date of the ITP, there should be other documentation showing that the client has been involved prior to that signature. Then, if the client does not sign until later, it is ok.

57. Does a therapist meeting with a supervisor to discuss a treatment plan which is due for review qualify as a treatment team meeting and is it thus billable as treatment plan development?

Answer: It depends; if the two meet for discussion of a client's progress on objectives, the client's input and the changes needed in the ITP, that could be treatment plan development, review and modification. However, a meeting to review the therapist's work and recommendations is not billable.

58. Is the parent or legal guardian required to sign off on MI documents if the client is an adolescent age 12 or older?

Answer: Rule 132 specifies signature requirements as: "The ITP and all its revisions shall be signed by the parent or guardian if the client is under 12 years of age. If the client is 12 through 17 years of age, the ITP shall be signed by the client and by the parent/guardian, as applicable, unless the client is an emancipated minor. A client 18 years of age or older or an emancipated minor shall sign the ITP. If the client is 18 years of age or older and has been adjudicated as legally incapable, the ITP shall be signed by the legally appointed guardian."

59. Would a signed statement like the following suffice in place of obtaining the client's signature on each treatment plan update? "The process for developing, review and modifying my Individual Treatment Plan has been thoroughly explained to me. I understand that all services that I receive from the agency are voluntary and that I may discontinue or refuse any service at any time. I understand that my treatment plan will be developed for my benefit and with my full participation and knowledge and that I will be given a copy of the Treatment Plan and all future revisions to the Plan. If I do not agree with anything in the Treatment Plan, I will ask that it be removed from the Plan. I understand that I may appeal any aspect of my Treatment Plan, now or in the future, with which I disagree to the agency's Program Director and/or Executive Director, as necessary. Understanding these provisions, I hereby provide my informed consent to my initial Treatment Plan and all future revisions of the Plan."

Answer: This is not at all acceptable. The client cannot sign off on all future anything at the beginning of or at any other point in service. The statement does not demonstrate active and on-going participation by the client in a process of recovery.

60. If a client does not come to review their treatment plan before it expires and a new treatment plan is completed when the client does come in, but it is after the expiration date of the last plan, and no services were provided before the new plan is developed, is this a problem and will billings either during the dates of the last treatment plan or during the time of the new treatment plan be impacted?

Answer: There are two parts to this. First, if a treatment plan is allowed to expire, the agency will be cited during a certification review. Second, if a treatment plan is allowed to expire, but no claiming is done during that period, then there will be no impact during a post payment review.

61. Can we complete an ITP with the consumer over the phone? Usually, we prefer to complete the treatment plans in person; however, in a rare occasion, we would like to use this opportunity to complete the ITP over the phone if we would still be meeting Rule 132 requirements. We would have the consumer sign the ITP at the next face-to-face meeting with the consumer.

Answer: Treatment plan development, review and modification may be delivered in person, by phone or video conference.

62. We always obtain an LPHA signature when a service or goal is added. What signatures are required when a goal on the treatment plan is added, modified, or changed? Can the continuity of care section on the treatment plan be modified without an LPHA signature? Some freedom from getting an LPHA signature would help to change the document more frequently.

Answer: All changes to the ITP must be signed by the Q, L, and the client/guardian.

63. Is the client/guardian signature required on the 6-month treatment plan review?

Answer: The Rule requires that the client/guardian sign the 6-month treatment plan review. Per rule, "Active participation by the client and/or persons of the client's choosing, which may include a parent/guardian, is required for all ITP development, whether it is the initial ITP or subsequent reviews and modifications. Participation by the client or parent/guardian shall be documented by the client's or parent's/guardian's signature on the ITP."

64. Does Rule 132 require that a list of current psychotropic medication be listed on the ITP?

Answer: If the provider is providing psychotropic medication services (132.150(c)), all medication prescribed for the client shall be listed in the client's clinical record.

65. Can you have multiple interventions for a single objective on a treatment plan?

Answer: Yes.

66. I have a question about the Delay of Services form that we use. I wonder if you could tell me if it is sufficient to hold up under MRO guidelines. If not, could you let me know what we need to do to change it?

Answer: While a form may document various reasons for delay in treatment plan development, it does not meet Rule 132 expectations. The ITP must be completed within 45 days following completion of the Mental Health Assessment and every six months after its completion.

67. When an MHP meets with a client for treatment planning development, review, modification, does the Q or L have to meet with the client face to face?

Answer: The rule does not require the QMHP or the LPHA to meet face to face with the client for treatment plan development, review or modification. We also want to caution you on best practice versus minimum requirements in the rule. The QMHP is designated as the responsible staff for the delivery of the services and the LPHA recommends medical necessity. It would be advantageous for the LPHA and QMHP to be familiar with the client and his/her needs, which may include a face-to-face meeting with the client. The MHA development as well as review, requires a face-to-face by the signing QMHP.

68. Rule 132 has a section on what is needed in an individual treatment plan. However the regional training has been promoting the use of recovery language. Can an ITP be called an Individual Recovery Plan?

Answer: There is nothing in rule that limits your ability to re-name an ITP. Regardless of the name, it must contain all required elements and staff must know what to produce when reviewers request to see an ITP.

69. I have heard different interpretations from Medicaid staff as to how to list the number of times a service is recommended on a treatment plan. Is minimum, range or maximum expected?

Answer: Use your best estimate on a specific number.

70. Some of our treatment teams are large and may involve 6 or 7 providers. One provider may be the Q and another, an LPHA. The way we read the rule is that as long as the QMHP, the LPHA and the client sign the ITP we can just list the other providers and their involvement per objective/task. Is this correct?

Answer: Yes, the Q, L and client must sign the ITP. Others listed on the ITP must only be the staff person who is responsible for implementation of each objective.

71. I am working with EPS hospitals in developing a procedure that will allow the clinics to receive a copy of the ITP for billing transition linkage and aftercare service. The hospital would include an intervention on the ITP and the clinic would request a copy of it. Must the hospital send to the clinic only the page with the problem, goal, and aftercare intervention, or the entire ITP?

Answer: It is important to give the clinic a copy of the objective(s) reflecting the need for transition and aftercare services, and the signature and date page.

72. We use the service description from the Service Definition & Reimbursement Guide to indicate an authorized service on the ITP. For example, we write Case Management-Mental Health, or Case Mgmt-Mental Health. Clinicians may also put our agency service activity codes next to the description for reference. We do not put DHS or HCPCS codes/modifiers in the ITP because the service description clearly indicates what the authorized service is. Listing multiple codes/modifiers takes a lot of space and time. To allow practitioners flexibility, and substantially reduce documentation time, our system translates agency codes to the appropriate codes/modifiers based on staff credentials, locations, and who we are billing, i.e. DHS, SASS/HFS, commercial insurance and/or Medicare. Recently, a surveyed agency was asked to write the DHS 2-digit codes on an ITP. Is this is a new requirement from your office?

Answer: There is no need to write DMH code numbers on the ITP as long as you have included the service as you described.

73. Can we prescribe both S2-CS-Group-MHP & S3-CS-Group-QMHP to meet one objective in a treatment plan? A consumer may receive services from both. The Q may run the group on Monday; the MHP may run it on Wednesday. Can the ITP look like this - Goal: To achieve mental health stability & reduce unnecessary hospitalization; Service: S2, S3; Frequency: 2 times weekly; Objective: Consumer will identify 2 community resources for stress management.

Answer: The ITP need only reflect CS-Group. You do not need to specify level of staff prescribed. You must, of course, bill for the actual level of staff providing the service. Additionally, there may be more than one service prescribed for any one objective.

74. When does the ITP become active, when developed and signed by the QMHP, when the client signs, or when it is signed by the LPHA?

Answer: The official active date of the ITP is the LPHA signature date.

75. Does the 6-month ITP review follow the date the LPHA signed, or the date it was developed by the QMHP?

Answer: The LPHA signature date.

76. Does the LPHA need to sign prior to any services on the ITP being provided?

Answer: Services included on the ITP may be provided following completion of the MH assessment as long as the ITP includes the service and is completed within the required time period.

77. I would like to describe our treatment team staff meeting for clarification about how this is billed. The plan is not developed in this meeting and the client is not there. It is discussed after the development and the Q is present in this meeting. If it is the ITP, this is discussed. If it is the MHP, then any changes made are discussed. This could be any change in the entire plan.

Answer: The rule does not specify that the client must be present when the ITP is developed, reviewed or modified. The part of ITP change that is not billable is the time during which the actual paperwork is done to make the changes.

78. Please clarify what is expected for treatment plan reviews. Is it ok to make a statement that the treatment plan was reviewed and all elements are to be continued, or must we specifically address each goal, objective, service, frequency, and staff? Must the 5-axis diagnosis be on the reviews as well as on the treatment plans?

Answer: Details for reviewing the ITP are in Rule 132. A current definitive diagnosis must be on the current treatment plan.

79. Do we have to identify a specific staff member for Community Support activities in the Treatment Plan? During Day 1 of the workshop - Rehabilitative Interventions, Fall of 2007 - under the Section listed CMH Proposed Rules for Rehabilitative Plan and under bullet 11 - it was stated that "Anticipated Providers be listed on the plan." On Day 2 of the Training it was listed that "under a Primary Community Support Model each consumer should have an identified primary community support staff member who serves as a point person for coordination and communication among staff." In an agency without a Primary Community Support model and where PSR and Community Support Services are offered by a small team of three, is the specific name of a staff member required when listing anticipated Community Support Services or can the treatment plan be more general? As a further complication, our agency has a Supported Residential Program and its clients are often in PSR services. Because of this, Community Support activities are often provided by both PSR and SRL staff in a cooperative manner. Therefore, in the treatment plan can we specify, for example - PSR or SRL staff will assist John to...?

Answer: If a consumer is receiving community support services per the ITP, a responsible staff person must be designated for each objective, either by name or by title if there is only one person in that title. Everyone providing the service is not required to be listed, only the responsible staff.

80. We had treatment plans that were off the 6 month review by a few days. No services were provided/billed for. We did get cited on this despite the fact that no services were provided during this lapse. In these cases, the reason for the delay was because the client was unable to participate for whatever reason until a later date. When we asked the auditors about what was more important, having the client participate in their tx plan or being off by a few days, they explained that the LPHA needed to sign off on the tx plan regardless if the client participated or not to ensure the 6 month deadline. Is this accurate?

Answer: There is no grace period for 6 month reviews. Our suggestion is to start sufficiently early engaging the client so that input is received and the 6 month deadline is still met. If the client is not currently in service, note this in the record. Then, when the client returns to service, complete a new MHA and ITP.

81. The Rule states that the LPHA/QMHP must review the ITP with the client and family, as applicable. Must the LPHA/QMHP document this review or is it simply attested to by their signature?

Answer: The client/family's involvement in reviewing the ITP should be documented in the client record.

82. Must we specify frequency for CS-Residential?

Answer: Yes.

83. What if a client refuses to review and/or sign their ITP, would you continue to document & consistently follow-up with attempts to obtain the client's review/signature, and for how long?

Answer: It is the client's choice to not review and/or not sign the ITP. The client involvement in reviewing and signing the ITP needs to be documented at the time of each ITP review.

84. The Rule requires that a discharge date be included in the ITP. Could you provide an example of how that standard may be met when planning for an individual whose impairment level is such that they will need some level of services into the existing future?

Answer: A philosophy of recovery is expected. It may be a transition goal rather than a discharge date.

85. Is it allowable to document "unknown on the ITP in regard to date of discharge or transition?

Answer: No.

86. Will services be denied payment if an audit determines that they exceeded the frequency indicated on the ITP?

Answer: Not if client circumstance changes and it is documented in the progress notes. If it is a substantial change, then there should be a mental health assessment which will result in a revision of the ITP.

87. If a case is out of compliance because ITP review was not timely, how do we get the case back into compliance, and how do we demonstrate this?

Answer: Complete the next ITP review within six months of the previous one and you will be in compliance again.

88. Does the rule define how often the ITP must be reviewed for children & adolescents?

Answer: No distinctions are made between children, adolescents and adults.

89. On non-ACT ITPs, what is the Department looking for in terms of recovery planning?

Answer: A philosophy of recovery is expected in all ITPs. Elements include: Hope; Self-Direction; Individual and Person-Centered; Empowerment; Holistic; Non-Linear; Strengths Based; Peer-Support; Respect; and Responsibility. For more information, contact the Recovery Services Specialist in your regional office.

90. Can the ITP frequency specify "up to 3x/wk" etc., or must it specifically state "3x/wk"?

Answer: No. It must be specific. 3x/wk is okay.

91. Please clarify the requirements for "Integrated Treatment Plan".

Answer: The client should have one treatment-plan that includes all mental health services provided by an agency. For specific requirements, please refer to Rule 132.

92. If a client refuses to sign their treatment plan, are we still allowed to bill for development of the ITP?

Answer: Yes.

93. Where does "behavioral intervention" fit under the current taxonomy?

Answer: Behavioral intervention is not a Rule 132 service. It could be appropriately addressed with a variety of Rule 132 services depending on the needs of the client.

94. ITP modification - it doesn't require a full staffing, correct?

Answer: Correct.

95. Can people in the same group be working on different goals/skills?

Answer: Yes.

96. Currently we use a treatment plan that includes doctor visits, case management and PSR. In addition, we use a specific PSR plan. Is this okay?

Answer: The Rule specifies that the agency must have one integrated treatment plan. You could have sections of the treatment plan that are more easily available to staff providing the PSR service, but all sections must be combined in one place as one treatment plan somewhere in the agency.

97. Regarding self-selected engagement in leisure -- if a staff member working in a drop-in center during evening hours is teaching someone to use transportation, is this billable?

Answer: If the mental health assessment and treatment plan identify an assessed need and the service is skills building, then it may be billable.

98. The ITP requires continuity of care; give an explanation of what you want regarding Continuity of Care.

Answer: This refers to planning with the consumer at the six month treatment plan review for the future. At this time, the treatment plan should be reviewed and discussed with the consumer to plan for changes and direction, for example - What is the direction of treatment? What changes are anticipated? What are the next steps for recovery? The intent is to assist a person to move toward community services and away from agency-based services (PSR). The Rule says that a discharge or transition date to be considered at the six month treatment plan review so that the consumer and staff are always looking toward a future of recovery. Sometimes a client progresses and then regresses. When there is no significant progress, this regular review assures that treatment planning with consumers occurs. This should never be presented as "This is the date we are going to discharge you".

99. How specific do deficits/goals on the treatment plan need to be?

Answer: The treatment plan must be based on the assessed needs of the client, must include the participation of the individual and their preferences. Goals and objectives must relate to the assessed needs which are part of the Mental Health Assessment. All ITPs must be individualized.

100. When an individual's treatment plan incorporates multiple services, does it have to be signed by all services? Answer: The treatment plan must be signed by a QMHP and LPHA. 103. For the ITP meeting, for any changes in service, does a QMHP or LPHA need to be physically present to sign off?

Answer: No, they don't need to be present, but changes are not effective until signed, and both QMHP and LPHA, as indicated by original signatures, are responsible for changes.

101. Regarding treatment plan goals, how specific do goals need to be? Can they be aimed at general categories?

Answer: You do not need a goal for each group. You need goals that meet the consumer's assessed need and services to meet that goal. A service could be PSR.

102. Our clients already choose groups that they want to be in. They request educational groups, such as mental health education, including history of mental health, and then provide

recommendations for specific mental health groups, i.e., depression group, for further information. Is this group billable?

Answer: Agencies should be very clear on the description for education groups. Psycho-education groups as described above can be very appropriate for gaining understanding of mental illness. What is not covered under PSR is academic education, for example, basic adult math group. And, all groups must relate to goal/objective on the ITP. A client may choose to participate in a group, but if there is no relationship to an assessed need as expressed by the MHA or ITP, then their participation would not be billable.

103. Regarding the frequency of CSI and CSG, do you need to put the frequency on the treatment plan?

Answer: Yes, include frequency on the treatment plan. Frequency should be reviewed in the six month review and adjusted as necessary.

104. For treatment plan development if a client has several goals, (self-advocacy, self esteem, socialization, etc), do you want a specific goal for each of these? Or can one goal be inclusive of all deficits?

Answer: Goals need to be written so that everyone knows what the person is working on. Objectives have to be measurable so staff and consumer know when the objective is accomplished. When you use a broad goal, neither the staff nor the client knows when it is accomplished or when things are progressing. The point of treatment planning is so the consumer knows why they are there. The treatment plan should be the guide for service delivery.

105. Regarding frequency of PSR listed in the treatment plan, you could have several activities that are listed under PSR to address goals. How would you deal with frequency of CS related to these goals?

Answer: Each time you list a service, indicate how often this service will be provided.

106. When a client's BPS and IP are due and they are in the hospital, jail, or missed their appointment, can the clinical supervisor use continuation of the current TP in the meantime to keep the documentation current?

Answer: MHA update and ITP reviews are due according to the timeline stated in rule. There are no exceptions. (2/22/11)

107. Do we need a LPHA signature on a progress note for a MHP gathering information on the client, which includes presenting problem, history of treatment and current functioning for MHA, via telephone, if it is billed as assessment? Upon review of Rule 132, I do not see where gathering information for MHA requires a QMHP and/or LPHA signature. Example: New client in hospital, call hospital for the above information, can this be billed as assessment. Also, after the completion of a MHA and client is referred to therapy and then the therapist assesses the need for case management services, can we complete a progress note, bill assessment which would justify the need for other services? Do we need a QMHP and/or a LPHA signature on this note? Do we need to complete a full assessment if we are adding services and billing assessment?

Answer: When a need for a service arises and that service is not on the ITP, the need may be documented in a note signed and dated by the staff person who determined the need. However, before the service may be provided the ITP must be updated and the ITP update must be signed and dated by the LPHA, QMHP and consumer. (2/22/11)

108. Regarding Rule 132 and treatment plan development and updates: When the provider is asked to list "staff responsible" for each service to be provided, should they list the title, the credential level, or what? Since staff come and go, I am assuming specific staff names should not be listed.

Answer: There must be a staff name unless a title points to a single staff person. If only one staff person is responsible for the delivery of all services, then just one name may be listed. In that situation, it must be clear that one person is responsible for all services. We do not require the name of each staff person that will provide a service, only the name of the person responsible for the delivery of service(s). (9/1/11)

109. Due to insufficient staff, can a provider just address some of the services in an ITP and defer the other services until they have more staff? This would allow them to minimally serve more clients.

Answer: Services may be prioritized based on consumer need, but not on provider staff availability. (9/1/11)

110. If progress toward goals and service interventions are not addressed on the ITP review itself, is it okay to use the note that documented billing for treatment plan review if it addresses progress and services to meet this criteria? If yes, what if the progress note that addresses ITP services has a different date than the ITP review? What if the date of the note is not even close in time to the ITP review (30 days apart for example)? Does the LPHA have to sign this note or is it okay for a QMHP to assess progress?

Answer: The Rule 132 Guidelines, Instructions and Checklist says the following in regard to the ITP review: (1) Six months is measured from the date of the LPHA signature on the previous plan to the date of the LPHA signature on the next full review. (2) The entire plan must be reviewed. (3) The review documentation must be signed and dated by the LPHA and the QMHP. Additionally, the rule requires that the LPHA and the QMHP shall review the ITP no less than once every six months to determine if the goals set forth in the ITP are being met and whether each of the services described in the plan has contributed to meeting the stated goals. The ITP shall be modified if it is determined that there has been no measurable reduction of disability or restoration of functional level. Therefore, addressing this in a progress note is not acceptable. (12/1/11)

111. Over the years in developing our treatment plans with the client, we would usually try to include a number of objectives (5 or more) to support each goal. We have a new employee who, at one time, worked at another agency who shared that at that agency, the practice was to have one objective to support the client's goal. Also, the Rule 132 services recommended to help the client attain the goal would be included in the plan. When writing the progress note, the goal # would be referred to, i.e. Goal 1; whereas, the way we currently document, we reference the goal # and objective #, i.e. Goal 1b. Please give your feedback on each of these practices. Also, is there a minimum requirement for goal objectives?

Answer: The rule doesn't specify a number of goals/objectives. The rule does specify that services must be designated on the ITP and must be medically necessary for achievement of goal/objective. How you do this depends upon the needs of the client and what it will take to achieve his/her goals. Progress notes documenting the delivery of services must be clear as to why something was done and the result of doing it. It's up to each provider to establish their formats. (9/1/12)

112. Our organization is working on modifying and streamlining our ITP document. We currently have a date at the top of the document called "Date of ITP" that matches the date of contact with the client. This date often differs from the date the ITP is reviewed and signed by the LPHA, which is the effective date of the ITP. Would it be allowable to have two dates at the top of the ITP document, a "Date of ITP Interview" and a "Date of ITP Implementation"? If this is not allowable, which is the appropriate date to designate on the ITP? Additionally, ITP objectives are valid for six months from the date of LPHA signature, correct?

Answer: Here are the requirements for completion and review of an ITP. The effective date of the ITP is the date that accompanies the LPHA signature. No other date needs to be indicated

on the ITP as an effective date.
The ITP doesn't need a date of contact with the client. The MHA requires a face-to-face with the client by the QMHP that signs the MHA report, and also requires a notation about the first face-to-face contact with the client as the date from which the 30 day time period for completion of the MHA is determined.
The client needs to be regularly involved in the development of the ITP, but the ITP itself doesn't need to document each of those contacts. Notes supporting billing for ITP development, review and modification would show client involvement.
An ITP must be reviewed every six months. However, that doesn't mean that ITP objectives are valid for six months. Objectives are valid as long as they are relevant to the delivery of medically necessary 132 services for the recovery of the client. (9/1/12)

113. It the ITP is due on April 1, but the person served does not show up, the LPHA writes an ITP on his own and signs it, then the person served comes in May 1, the LPHA review the ITP with the person served and they make no changes from the April 1 ITP, the person served signs it and the LPHA signs it again, which date is the effective date of the ITP from which the 6 months begins for the next review?

Answer: An ITP is always effective the date the LPHA signs. In the situation you presented, the LPHA doesn't need to sign again and the 6 month review would be from April 1. Since the person served is always an active participant in their service delivery, the LPHA should be aware of what needs to be changed, if anything and should already have input from the person served before the specific six month date. Therefore, the review of the plan should be based on six months' worth of treatment and discussion and not then dependent upon the person served being there on a particular date. (3/1/13)

114. If we are providing services to an individual age 12 - 17 and the parent has consented to services, but the adolescent states that they would not like their parent involved in their treatment planning, is it acceptable for the treatment plan NOT to be signed by the parent/guardian in this instance?

Answer: Yes, the parent is required to sign the ITP. According to the Confidentiality Act a parent cannot be blocked from seeing assessment results and treatment plans. Since this is the case, and because Rule 132 requires it, there is no exception to the parent signing. That said, it is certainly up to clinical judgment how much the parent is involved in the treatment past the planning process. (6/1/13)

115. A client is open to our child and family counseling program with a valid MHA and ITP. SASS is activated and the client is then opened to the SASS program and closed to the child and family program. A new treatment plan is done in the SASS program. Does an ITP review need to be completed for the child and family program in order to satisfy the 6 months ITP review requirement or does the new SASS treatment plan start the 6 months over?

Answer: Rule 132 defines services, not programs. SASS is a funding stream, not a program. With that said, we reviewed this with the following possible scenario. A C & A client was receiving Rule 132 services based on an MHA and ITP. That client experienced a crisis and was assessed by SASS. As a result of the SASS assessment, a new ITP was developed for Rule 132 services. The MHA should be updated to reflect the SASS assessment findings. The new ITP should reflect the update MHA. The date of the new ITP becomes the date on which required reviews are based. There should not be two ITPs. (12/1/13)

116. Does a consulting psychiatrist have to sign the initial consent for services or the treatment plans? I know that Rule 132 states that an LPHA has to sign them, but I wasn't sure if that is the case since we have the DHS Psych contract. Can you tell me what parts of the client file need a psychiatrist signature?

Answer: Per Rule 132, the staff, including a psychiatrist, providing a service must sign and date the documentation that the service was provided. Additionally, some Rule 132

psychotropic medication services may be delegated by a psychiatrist to other staff. That authorization must be signed and dated by the psychiatrist. DMH capacity grant 350 is not related to Rule 132 service provision requirements. (12/1/13)

117. If an updated Treatment Plan is signed by the LPHA in our electronic record at 7:10pm, but one or more clinical services were provided and documented in our electronic record at 3:30pm, prior to the LPHA signature on the ITP, are those services billable? Also, please be aware that upon initiating a new Treatment Plan within our HER, the previous plan is automatically voided and is replaced by the new plan.

Answer: An ITP is effective with the signing by the LPHA. Because the LPHA's signature is time and date stamped, that is the effective time of the ITP. No services may be billed prior to the ITP being effective. As for your system voiding one ITP and replacing it with another, we're not clear what that means. However, it is critical that "old" plans be maintained and made available to demonstrate Rule 132 compliance. (9/1/14)

118. May a Rule 132 service provider use a mental health assessment completed by another provider who is also serving the client?

Answer: Every provider must have a current mental health assessment in the own client files. Additionally, their own staff L and Q must sign it as required by rule. Although, a provider may not be the original author of the MHA, each provider using it is responsible for assuring that it complies with all Rule 132 requirements. (12/1/14)

119. When we've been serving someone by providing Rule 132 services, and in compliance with Rule 132 requirements, but their services have been paid by someone other than DMH, must we complete a new MHA when DMH becomes the funder?

Answer: As long as all Rule 132 requirements have been met in your mental health assessment and it is current according to rule requirements, there is probably not a need to redo it. Please remember that the mental health assessment must have identified and recommended the direction for treatment based on assessed needs and medical necessity. (12/1/14)

120. If a psychiatrist changes an Axis 1 diagnosis by changing a modifier, or adds or deletes an additional diagnosis such as Tobacco Abuse, does this necessitate a new treatment plan? If the change in diagnosis does not affect the treatment plan's goals or objectives, is a revision needed to indicate the change in diagnosis by the psychiatrist?

Answer: Treatment plans must be reviewed according to the schedule in Rule 132. Additionally, if the original diagnosis of mental illness changes in a way that impacts the course of treatment, then the MHA and ITP must be updated to reflect that change in diagnosis and the subsequent change in treatment approach. (12/1/14)

121. We have been listing all Rule 132 services for which we are certified on every treatment plan. Is this acceptable?

Answer: No, it is not. All services that the LPHA believes the client may need, even if those services are not all going to be provided immediately, but at some time during the six month period of the ITP should be listed on the ITP. The ITP should always reflect actual treatment being provided in response to the mental health assessment recommendations. (12/1/14)

122. Is it permissible to have as documentation of a mental health assessment or individual treatment plan being done the copy of the MHA report or the ITP in the client's file?

Answer: No, there must be a note in the recode describing what was done, when it was done and by whom it was done with the staff person's signature, date and credential. This is the same for the provision of all Rule 132 services. (6/1/15)

123. If an MHA identifies certain needs and the MHA report includes goals and services related to those needs, but by the time the ITP is developed within 30 days later, the client has identified only some of those goals as ones to address now, is it ok for the ITP to differ from the MHA report and how do we document the difference? Or, is an MHA addendum required any time the ITP isn't going to address all needs/goals identified in the MHA report?
Answer: There is no requirement that all recommendations from the MHA must be incorporated into the ITP. The only time that goals and services are required to be on the MHA report is if there is a time gap between the MHA completion and the ITP completion, as in your example, and services are provided during that gap. When the goals have been included on the MHA, and then not on the ITP, there must be documentation of why there has been a change. There should be more information than just the client doesn't want to work on all of them. (6/1/15)

124. If the ITP is not completed and signed by the LPHA within 45 days, is it necessary to complete a new ITP in order to be considered compliant with Rule 132? Or is it sufficient to sign the ITP when it is completed and use the LPHA signature date as the effective date even if it is after 45 days?

Answer: "Re-doing" the individual treatment plan would not "reset" the 45 day clock. Rule 132 does not require a client to be present for an LPHA to complete the treatment plan. However, the plan should be reviewed with the client and modified as needed at the next contact with the client if it is completed without their presence. (4/5/16)

125. Does Rule 132 require that an agency translate treatment plans for the parents of clients between 12-17 years of age? The parents only speak Spanish.

Answer: Rule 132 requires that the provider must ensure the availability of a staff or consultants capable of using languages or methods of communication used by the individuals they serve, and that they must explain the process for development, review, and modification of the treatment plan to both the client and the parents. If the parents have LEP, then the explanation must be communicated in a language or method understood by the parents. (4/19/16)

126. I would like to clarify that the state requires SMART goals for the MH/PSR. Would you then agree that a goal is written for the client, meaning not how many times a staff is doing but how many times the client is actually demonstrating the task after instruction and/or support is provided?

Answer: You are correct that both the goals and outcomes of treatment should be measureable. However 132.148.c.2.D states: The amount, frequency, duration of Part 132 services to be provided. Thus, this is a reference to how much and how often the service interventions are provided and are not related to the measurement of the goals/objectives of treatment. (5/17/16)

127. If an MHA is completed and signed but the ITP is not completed 45 days or less from the MHA, we understand that the services during the 45 day time frame are invalid. Does this mean that services provided after our late ITP is signed are also invalid? If so, how do we correct for this?

Answer: When there is more than a 45 day period of time between the mental health assessment report and the development of a treatment plan, findings can occur in both post payment reviews, which would result in unsubstantiated claims, as well as within a certification review completed by the certifying agency.

128. First, for post payment review: Rule 132 allows for services to be provided during the period of time that a treatment plan is being developed, as long as the mental health assessment report is completed, signed, and dated by the LPHA or the Admission Note is signed/dated by the QHMP or the Healthy Kids mental health screen is completed by a physician is in the client record **and** the specific service is recommended as medically necessary on the authorizing document list above **and** once completed, the service is included on the individual treatment plan.

So, services provided within the 45 days of completion of an MHA are considered authorized for reimbursement so long as these conditions are met. Once those 45 days have passed, no further services that the Rule requires be included on a treatment plan in order to be billed may be billed for reimbursement until completion of a treatment plan. Any claims submitted from day 46 until the date the ITP is signed by the LPHA would be considered unsubstantiated in a post payment review. Once there is a valid treatment plan, dates of services authorized by that treatment plan may be billed.

Now for certification review: Rule 132 requires a treatment plan to be completed within 45 days of the completion of the MHA report (each of these is considered complete upon signature by the LPHA.) If there is more than a 45 day time period between the MHA and ITP, then this would be a finding in a certification review, as it is outside the requirements of the Rule. There are no steps to take to correct this; it is simply something that would be a violation at the time of the certification review. (6/28/16)

129. When writing a treatment plan, are providers required to place the intervention necessary to treat the objective under *each* objective it would treat? For example, let's say there were two separate goals with two separate objectives, but both objectives required group therapy. Can a provider put "1 hour Group Therapy weekly per 6 months" under one objective to apply for the entire plan or do all objectives need to repeat the intervention recommended? Are providers able to bill interventions for different objectives?
Answer: The provider should identify appropriate interventions for each objective. (9/2/16)

130. We know and follow the strict rule of the LCSWs signature being required on the ITP and that this is the signature that is the official start date for the ITP. We have a couple of contractual psychiatrists who see clients for us onsite. Specifically for these clients who will be seeing our own psychiatrist does the ITP need to be reviewed and signed off by the Psychiatrist. Is the ITP then considered active only after the Psychiatrist signs it?
Answer: Rules 132.148(c): 1) The initial ITP shall be completed within 45 days after the completion of the mental health assessment as documented by the **LPHA's** dated original signature with credentials on the ITP. When an Admission Note or Health Kids mental health screen was completed to initiate services, the ITP shall be developed, following the completion of a mental health assessment, within 30 days after the Client's date of admission. 4) Responsibility for development, review and modification of the ITP shall be assumed by a QMHP as documented by his/her dated original signature with credentials on the ITP. MHPs may participate in the development of the ITP. **An LPHA shall provide the clinical direction of mental health services identified in the ITP as documented by his/her dated original signature with credentials on the ITP**. 5) The LPHA and the QMHP shall review the ITP no less than once every 6 months from the date of the LPHA original signature on the most recent ITP to determine if the goals set forth in the ITP are being met and whether each of the services described in the plan has contributed to meeting the stated goals. The ITP shall be modified if it is determined that there has been no measurable reduction of disability or restoration of functional level. So the requirement is for LPHA, which could

be any of the following: Licensed Practitioner of the Healing Arts or LPHA – An Illinois licensed health care practitioner who, within the scope of State laws, has the ability to independently make clinical assessment, certify a diagnosis and recommend treatment for persons with a mental illness and who is one of the following: a physician, an advanced practice nurse with psychiatric specialty licensed under the Nurse Practice Ace [225 ILCS 65]; a clinical psychologist licensed under the Clinical Psychologist Licensing Act [225 ILCS 15]; a licensed clinical social worker (LCSW) licensed under the Clinical Social Work and Social Work Practice Act [225 ILCS 20]; a licensed clinical professional counselor (OCPC) licensed under the Professional Counselor and Clinical Professional Counselor Licensing Act [225 ILCS 107]; or a licensed marriage and family therapist (LMFT) licensed under the Marriage and Family Therapist Licensing Act (225 ILCS 55] and 68 Ill. Adm. Code 1283. It is not mandatory to have a signature on the ITP from the psychiatrist. (2/7/17)

131. Could you please clarify for me regarding the 45 days one has to complete the individualized treatment plan once the comprehensive assessment is done: Does "45 days" refer to business days or is it Monday through Sunday regardless of holidays?

Answer: The Rule defines "day" as follows: Day – A calendar day unless otherwise indicated. (12/13/16)

132. Rule 132 requires that the ITP be completed within 45 days of the LPHA's dated signature on the completed MHA. If the client does not initially engage (and receives no Rule 132 services during the 45 day period) but does finally engage on, say day 50, can we complete the ITP without having to update or complete a new MHA?

Answer: As you have stated, Rule 132 requires that the ITP can be completed within 45 days of the LPHA's dated signature on the completed MHA. The MHA needs to be updated if the ITP is completed after 45 days. (9/2/16)

133. The text of Rule 132 states that the Confidentiality Act states: "The following persons shall be entitled, upon request, to inspect and copy a recipient's record or any part thereof:…..the ITP shall be given…..as applicable…." Which seems like it means that the ITP needs to be given to the patient whenever the patient requests it. However, the way DMH, via audit and Q&A guidance has interpreted the text of the Rule is that the patient must be given a copy of the treatment plan always (**whether there is a request or not**). Rule 132 "Pursuant to the Mental Health and Developmental Disabilities Confidentiality Act [740 ILCS 110], a copy of the signed ITP shall be given to the client and the client's parent/guardian, **as applicable**." The guidance being given via audits and Q&A is that the ITP needs to be given to the patient **always** which may be more than what the regs require.

Answer: It has consistently been the expectation of the DHS Division of Mental Health that the interpretation of Rule 132 that a copy of the ITP shall be given to the client. The "as applicable" phrase refers to the client's parent/guardian, as not all clients have a parent/guardian with a right to a copy. (9/2/16)

134. Our agency has created a treatment plan with measurable objectives including the frequency, length of sessions, and target date. These objectives/services will be offered for every client. When developing each individual treatment plan (ITP) per client, is it acceptable to use the same measurable objectives, as long as the <u>GOALS</u> for each client are <u>individual in the clients own words</u>?

Answer: No, it is not acceptable to use the same measurable objective for every treatment plan. Treatment plans should be individualized, recovery oriented and person centered. (11/28/16)

135. Please provide us with some guidance as to what would be the best way and Rule 132 friendly, to document in the discharge criteria section.

Answer: The requirements set forth in section 132.148(c)(6) state: The IEP review shall include continuity of care planning with the client or the client's parent/guardian. The ITP review shall also include an estimated transition or discharge date and identify goals for continuing care. How an agency formats this information is not governed by Rule and thus the State does not opine on an agency's format. You are encouraged to review the Q&A's on the DHS website to review the State's response to other questions regarding Continuity of Care. (11/17/16)

136. We received feedback on a recent audit that if a consumer does not request a specific service during the assessment process and the service is not recorded on the assessment under the "client preferences to service" section it should not prescribed on the treatment plan. The feedback said that if additional services were prescribed other than what the consumer requests (even if medically necessary) it would demonstrate the "staff is driving treatment versus the consumer". This feedback required a plan of improvement by our agency. My question is, what do you do if a consumer does not understand their need for additional services? Or what if the consumer does not understand what a service is when we explain the additional services available to them? For example, many of our consumers request individual therapy. The clinician determines that the client has many other professionals on the case that are going to require consultation so case management client centered consultation is prescribed on the treatment plan. The consumer did not request this service as they do not understand what the service is or how it will benefit their case. Or in the cases of children, it is clear individual and family therapy are going to be needed but the child is angry and says they do not want to participate in therapy? Can we then not prescribe those services for the child?

Answer: This question is related to a Clinical Practice Guideline (CPG) review which does not fall within the purview of the Interdepartmental Rule 132 Q&A process. It has been referred to DMH for a response. (11/17/16)

137. Rule 132 says that treatment plan work can occur through video-conferencing, so is it permissible for an appointment to happen through Video Phone? Video phone is essentially video-conferencing between two individuals and is secure through Firewalls for confidentiality. The client is an 81 year old deaf woman that has problems getting out due to asthma. The therapist sees a need for therapy.

Answer: Rule 132 does not specify the types of video conference technology that can be used. However it does reference certain Acts that must be followed in the treatment of individuals. The agency should be sure that the technology they use meets the requirements of the Mental Health Confidentiality Act, the Health Insurance Portability and Accountability Act, and the Health Information Technology for Economic and Clinical Health Act. (2/7/17)

138. What do we do in cases where we complete a treatment plan on someone's behalf because they did not attend the treatment planning session? Should we still have them sign the next time we see them? Should they sign with the original date or the date they see it? If they sign and date later than it was due, does that make us out of compliance?"

Answer: Please refer to the posted Question & Answers regarding treatment planning on the DHS website at the following link: http://www.dhs.state.il.us/page.aspx?item=53143. Similar questions

have been asked and answered, specifically #21, #22, #36, #56, #62, #63, #74, #75, #76, #77, #81, #83, #92, #124, #127. (4/11/17)

139. After our recent BALC audit, there seems to be some confusion about how long our agency has to get a client back for a 6 month treatment plan. We have understood it to be 6 months, but it seems that some of the staff were under the impression that there is a 30-day grace period after the due date. For example, if a client came in for an initial treatment plan on July 1, their 6 month treatment plan would be due on January 1. However, if for some reason the client was not able to make it in on or before January 1, is there any period of time after the 6 month due date that they have to get in for their updated treatment plan? In this example, that would mean the client would have until January 30 perhaps to come in to complete the 6 month treatment plan. All in all, I would just like to get some clarity on whether or not the 6 months date is flexible at all or not.

    Answer: There is no grace period for 6 month reviews. Our suggestion is to start sufficiently early engaging the client so that input is received and the 6 month deadline is still met. If the client is not currently in service, note this in the record. Then, when the client returns to service, complete a new MHA and ITP. (4/18/17)

140. Is it acceptable to list all services that will be provided for one objective? For example, if the objective is to utilize coping skills in order to decrease angry outbursts, can the 132 services be CSI, therapy counseling, and PSR? The individual may be working on that objective in many groups in day services.

    Answer: Yes. It is acceptable to list all services that will be provided for one objective. (6/6/17)