

Treatment Planning



What is expected in a Medicare Behavioral Health Treatment Plan?

When auditors request medical records, the documentation should be legible, complete, signed and dated by the provider responsible for that patient's care. However, aside from the above, what exactly are they auditing?

One audit focus area that Medicare emphasizes is the active treatment plan. Each Medicare behavioral health record must reflect the degree and intensity of treatment and must be recorded in the patient's medical record in accordance with 42 CFR 482.61, Conditions of Participation for Hospitals.

Treatment plans must be individualized plans and based on an inventory of the patient's strengths and disabilities that include: (1) a substantiated diagnosis, (2) short-term and long-range goals, (3) specific treatment modalities utilized, (4) responsibilities of each member of the treatment team, (5) adequate documentation to justify the diagnosis, treatment and rehabilitation activities carried out.

Short-term and Long-range Goals: These goals must include specific dates for expected achievement. As goals are achieved, the treatment plan should be revised. When a goal is modified, changed or discontinued without achievement, the plan should be reviewed for relevancy, and updated as needed. Long range goals generally represent discharge criteria, thus the target discharge date can serve as the target date. The long-range goal is achieved through the development of a series of short-term goals, (i.e., smaller, logical sequential steps). Both the short-term and long-range goals must be stated as expected behavioral outcomes for the patient and be related to the problems identified for treatment. Goals must be written as observable, measurable patient behaviors to be achieved.

Specific treatment modalities must be itemized and detailed, (e.g., type, amount, duration, etc.). Simply documenting the modality treatment (e.g. individual/group therapy/occupational therapies, etc.) is not acceptable and the focus of treatment must be included. Documentation in the patients' record should reflect the frequency in which the treatment plan is assessed to assure that all active efforts are included and the patient's response to the treatments.

The intent of the regulation is to insure that each individual on the treatment team who is primarily responsible for ensuring compliance with particular aspects of the patient's individualized treatment program is identified. Identification of the staff should be recorded in a manner that includes the name and discipline of the individual. If other professionals or paraprofessionals provide care, the facility has the latitude to decide the manner with which it will identify them on the treatment plan.

Although the stated requirements may vary in the Medicare hospital inpatient and outpatient manual locations, Medicare Hospital Conditions of Participation (CoP) apply to both inpatient and outpatient services of the hospital. Thus, it can be anticipated that documentation expectations outlined in the psychiatric hospitals manual be applied to the outpatient setting and vice versa.

Helpful References:

Medicare Internet Manuals

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html>
<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c02.pdf>

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