1. Individualized Treatment Plan
    a. A written individualized treatment plan, referred to as Treatment Plan, is a comprehensive, progressive, personalized plan that includes all prescribed Behavioral Health (BH) services. It is person-centered, recovery oriented, culturally competent and addresses personalized goals and objectives. The objective is to reduce the duration and intensity of medical services to the least intrusive level possible while sustaining overall health. BH services are designed to improve the recipient's functional level based on achievable goals and objectives. The Treatment Plan must consist of services designed to achieve the maximum reduction of the health disability and restore the recipient to a functional level of independence.
    b. Each prescribed Outpatient Mental Health (OMH) and Rehabilitative Mental Health (RMH) service within the treatment plan must meet medical necessity criteria, be clinically appropriate and must utilize evidence-based standards
    c. The prescribed services within the plan must support the recipient's restoration of functioning consistent with the goals and objectives.
    d. Be integrated or coordinated with other components of overall health care.
    e. The recipient-centered treatment plan must include strength based, outcome-oriented individualized rehabilitation goals and objectives. These goals and objectives are to accomplish specific, observable changes in skills and behaviors that directly relate to the recipients individual diagnosed condition(s). BH services must be recovery-oriented.
2. Treatment Plan Development
    a. The Treatment Plan must be developed jointly with:
        i. The recipient; or the recipient's legal representative (in the case of legal minors and when appropriate for an adult);
        ii. The recipient's parent, family member, guardian, or legal representative with given consent from the recipient if determined necessary by the recipient;
        iii. QMHP;
        iv. All BH services requested must ensure that an individual's condition shall be reduced and functional levels restored per the therapeutic intent of the services requested.
    b. All requested BH services must ensure that all health professionals incorporate a coherent and cohesive developed treatment plan that best serves the recipients needs.
    c. Services should promote collaboration between other health providers, community supports and identified stakeholders to ensure care coordination and continuity of care.
    d. The requested services are to be specific, measurable and relevant in meeting the goals and objectives indentified. The provider must identify within the Treatment Plan the scope of services to be delivered, and are not duplicative or redundant of other prescribed BH services.
3. Required information on Treatment Plan

a. Treatment Plans are required to include at least the following information:
    i. Recipient's full name;
    ii. Recipient's Medicaid or Nevada Check Up billing number;
    iii. Intensity of Needs determination
    iv. Severe Emotional Disturbance (SED) or Serious Mental Illness (SMI) determination:
    v. Date of determination
    vi. The name and credentials of the provider who completed the determination
b. Goals and Objectives: The individualized treatment plan must establish a measurable basis for evaluating the effectiveness of all prescribed BH services prescribed in meeting the plan's stated recovery goals and objectives.
c. Prescribed Services:
    i. Services: Identify the specific behavioral health service(s) (i.e., family therapy, individual therapy, medication management, basic skills training, day treatment, etc.) to be provided;
    ii. Scope of Services and Duration: Identify the daily amount, service duration, and therapeutic scope for each service to be provided;
    iii. Providers: Identify the provider or providers who are responsible for implementation of each of the plan's goals, interventions, and services;
    iv. Rehabilitated Services: Document that the services have been determined to be rehabilitative services consistent with the regulatory definition.
    v. Care Coordination: Identify and develop care coordination when multiple providers are involved with a recipient's services;
    vi. Strength-Based Care: Collaboratively develop a treatment plan of care involving the strengths of the recipient and family (when applicable);
    vii. Declined Services: If the recipient declines recommended service(s), this act must be documented in the treatment plan.
d. Discharge Plan must identify:
    i. The planned duration of the overall services;
    ii. Discharge criteria;
    iii. Recommended aftercare services;
    iv. Identify available agency(ies) and Independent Provider(s) to provide aftercare services (i.e. community-based services, community organizations, nonprofit agencies, county organization(s) and other institutions);
    v. A plan for assisting the recipient in accessing these services to support the recipient aftercare.

4. Required Signatures

a. Signatures required on all treatment plans, modifications to treatment plans and reevaluations of treatment plans include:
    i. Clinical Supervisor and their credentials;
    ii. Recipient, recipient's family or their legal representative (in the case of legal minors and when appropriate for an adult);
    iii. The individual QMHP and their credentials responsible for developing and prescribing the plan within the scope of their licensure.

5. Treatment Plan Reevaluation: A QMHP must evaluate the treatment plan every 90 days or more often if needed. A brief analysis is required addressing whether each of the services prescribed in the plan has contributed to meeting the clinically established goals and objectives.
    a. If it is determined that there has been no measurable restoration, a new recipient-centered treatment plan must be developed.
    b. All recommendations and changes to the treatment goals, objectives, strategies, interventions, frequency, or duration; any change of individual providers, or any recommendation to change individual providers; and the expected duration of the medical necessity for the recommended changes must be identified in the new plan.
    c. The new treatment plan must be a recipient-centered rehabilitative approach that includes participation from the recipient the recipient's legal representative (in the case of legal minors and when appropriate for an adult), and family which identifies measurable reductions to the diagnosed mental disability in terms of restored functional abilities.
6. Progress Notes: The written documentation of the treatment, services, or services coordination provided which reflects the progress, or lack of progress towards the goals and objectives of the Treatment Plan.
    a. All progress notes reflecting a billable Medicaid behavioral health service must be sufficient to support the billing of the services provided and must document the amount, scope, duration and provider of the service(s).
    b. An individual Progress Note is required for each day the service was delivered and must include the following information:
        i. The name of the individual receiving service(s);
        ii. The place of service;
        iii. The date the service was delivered;
        iv. The beginning and ending time of day the service was delivered;
        v. The billing code and modifier (if any) used to describe the service;
        vi. The number of service units delivered;
        vii. The name of the provider who delivered the service;
        viii. The credentials of the person who delivered the service;
        ix. The signature of the provider who delivered the service;

x. The goals and objectives being worked on; and
xi. The recipient's progress towards attaining the identified treatment goals and objectives

c. Temporary, but clinically necessary, services do not require an alteration of the treatment plan; however, these types of services, and why they are required, must be identified in a progress note. The note must follow all requirements for progress notes as stated within this section.

7. Discharge Summary: Written documentation of the last service contact with the recipient, the diagnosis at admission and termination, and a summary statement describing the effectiveness of the treatment modalities and progress, or lack of progress, toward treatment goals and objectives as documented in the Treatment Plan. The Discharge Summary documentation must include the reason for discharge, current intensity of needs level and recommendations for further treatment.
    a. Discharge summaries are to be completed no later than 30 calendar days following a planned discharge and 45 calendar days following an unplanned discharge.
    b. In the case of a recipient's transfer to another program, a verbal summary must be given at the time of transition and followed with a written summary within seven calendar days of the transfer.