

**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**  
**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**  
**PART 6. INPATIENT PSYCHIATRIC HOSPITALS**

**317:30-5-95.33. Individual plan of care for children**

(a) The following words and terms, when used in this section, shall have the following meaning, unless the context clearly indicates otherwise:

(1) **"Licensed Behavioral Health Professional ~~(LBPH)~~ (LBHP)"** means licensed psychologists, licensed clinical social workers (LCSW), licensed marital and family therapists (LMFT), licensed professional counselors (LPC), licensed behavioral practitioners (LBP), licensed alcohol and drug counselors (LADC), and advanced practice nurses (APN).

(2) **"Individual plan of Care (IPC)"** means a written plan developed for each member within four calendar days of any admission to a PRTF and is the document that directs the care and treatment of that member. The individual plan of care must be recovery focused, trauma informed, and specific to culture, age and gender and includes:

(A) the complete record of the DSM-IV-TR five-axis diagnosis, including the corresponding symptoms, complaints, and complications indicating the need for admission;

(B) the current functional level of the individual;

(C) treatment goals and measurable time limited objectives;

(D) any orders for psychotropic medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the health and safety of the patient;

(E) plans for continuing care, including review and modification to the plan of care; and

(F) plan for discharge, all of which is developed to improve the child's condition to the extent that the inpatient care is no longer necessary.

(b) The individual plan of care:

(1) must be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the individual member and reflects the need for inpatient psychiatric care;

(2) must be developed by a team of professionals as specified in OAC 317:30-5-95.35 in collaboration with the member, and his/her parents for members under the

age of 18, legal guardians, or others in whose care he/she will be released after discharge;

(3) must establish treatment goals that are general outcome statements and reflective of informed choices of the member served. Additionally, the treatment goal must be appropriate to the patient's age, culture, strengths, needs, abilities, preferences and limitations;

(4) must establish measurable and time limited treatment objectives that reflect the expectations of the member served and parent/legal guardian (when applicable) as well as being age, developmentally and culturally appropriate. When modifications are being made to accommodate age, developmental level or a cultural issue, the documentation must be reflected on the individual plan of care. The treatment objectives must be achievable and understandable to the member and the parent/guardian (when applicable). The treatment objectives also must be appropriate to the treatment setting and list the frequency of the service;

(5) must prescribe an integrated program of therapies, activities and experiences designed to meet the objectives;

(6) must include specific discharge and after care plans that are appropriate to the member's needs and effective on the day of discharge. At the time of discharge, after care plans will include referral to medication management, out-patient behavioral health counseling and case management to include the specific appointment date(s), names and addresses of service provider(s) and related community services to ensure continuity of care and reintegration for the member into their family school, and community;

(7) must be reviewed every five to nine calendar days when in acute care and a regular PRTF and every 11 to 16 calendar days in the OHCA approved longer term treatment programs or specialty PRTF treatment programs by the team specified to determine that services are being appropriately provided and to recommend changes in the individual plan of care as indicated by the member's overall adjustment, progress, symptoms, behavior, and response to treatment;

(8) development and review must satisfy the utilization control requirements for physician re-certification and establishment of periodic reviews of the individual plan of care; and,

(9) each individual plan of care review must be clearly identified as such and be signed and dated individually by the physician, LBHP, member, parent/guardian (for patients under the age of 18), registered nurse, and other required team members. Individual plans of care and individual plan of care reviews are not valid until completed and appropriately signed and dated. All requirements for the individual plan of care or individual plan of care reviews must be met or a partial per diem recoupment will be merited. In those instances where it is necessary to fax an Individual Plan of Care or Individual Plan of Care review to a parent or OKDHS/OJA worker for review, the parent and/or OKDHS/OJA worker may fax back their signature. The Provider must obtain the original signature for the clinical file within 30 days. Stamped or Xeroxed signatures are not allowed for any parent or member of the treatment team.