471-000-96 Form MC-83 "Mental Health/Substance Abuse Treatment Planning Document for Outpatient Services" and Completion Instructions

Use: Mental health/substance abuse providers use Form MC-83, "MHSA Treatment Planning Document for Outpatient Services" to document the evaluation of a client before providing services, to outline an active plan of care, and to continuously review and update this plan of care. Providers may substitute a treatment planning document of their own design containing all components of Form MC-83. It is appropriate to review the treatment planning document (or Form MC-83) with the client and the client's family.

For outpatient services, the treatment planning document (or Form MC-83) must be reviewed and updated with the supervising practitioner and client, every 90 days or more often if medically necessary. Refer to Medicaid regulations at 471 NAC 20-000 and 32-000 for other levels of care.

Substance abuse treatment is covered only for clients age 20 and under.

Completion: Form MC-83 is completed as follows. Use the back of the form if additional space is needed. Substitute treatment planning documents must include the following information. Note: If a medication check **only** is being done, complete Items 1-11, 14-17b, 25 and 27.

Items 1-5: Enter the client's name, Medicaid number, an indication of whether this is an initial report or an update, client's sex and age.

Item 6: Enter the date the most current Health Check was completed for clients age 20 and under.

Item 7: Enter the date the biopsychosocial component of the Pretreatment Assessment was completed.

Item 8: Enter the date of the Initial Psychiatric Diagnostic Interview of the Pretreatment Assessment by the supervising practitioner. The supervising practitioner must be a physician or licensed psychologist. If the supervising practitioner changes, the date in this field would also change to reflect the updated Initial Psychiatric Diagnostic Interview by the new supervising practitioner.

Item 9: Enter the date the treatment plan is completed or updated. This date must match the date in Item 32. This date indicates the beginning of the coverage time of this treatment plan.

Item 10: Enter the date of onset of the client's current active symptoms or functional impairments.

Item 11: Describe the client's current acute mental health/substance abuse symptoms and functional impairments. This description must reflect the diagnoses as identified in Items 14-17.

Item 12: Describe any medical, legal, social, educational, occupational or other problems that may be affecting the client's symptoms, progress or prognosis.

Item 13: Enter the

(1) dates of consultations
(2) names and titles of professionals (other physicians and therapists) involved in the consultation
(3) a brief statement of what the consultation involved

Item 14 - 17: Enter all five DSM axes diagnosis codes. **(The claim must be completed using the ICD-9 diagnosis codes.)**

Item 18: Enter the progress or complications in the client's life which may be affecting treatment. Describe the level of client/family participation in treatment. (Narrative summary)

Item 19: Enter the anticipated **short term** goals (expected outcome in **30 days).** These goals must relate to the diagnosis, symptoms or functional impairment as identified on this document.

Item 20: Enter anticipated **long term** goals (expected outcome in **90 days to one year**). These goals must relate to the diagnosis, symptoms or functional impairment as identified on this document.

Item 21 - 26: Describe all treatment modalities prescribed for the client. Frequency of treatment and educational title of therapist must be listed for the modality being provided.

*Note: If clients are receiving services from more than one provider (including Community Treatment Aides) during the same time period there must be **ONE** coordinated treatment plan (or Form MC-83) for each client regardless of the number of providers*.

Item 27: List any known medication prescribed with dose and frequency. Indicate who prescribed the medication.

Item 28a: Enter the anticipated length of treatment (months)
28b: Enter the anticipated number of sessions until termination of treatment
28c: Enter targeted discharge date (month/year).

Item 29: Enter specific information regarding transition and discharge planning. This information would focus on the active mental health/substance abuse treatment (not living arrangement). The discharge plan should include change in frequency of services and transition into community services. (i.e., community support groups, vocational services).

Items 30 - 31: Enter the provider name and Medicaid number. **Please print.**

Item 32: Signature Lines: The supervising practitioner (physician or licensed psychologist) must sign and date the treatment planning document or Form MC-83. This signature indicates that:

(1) the supervising practitioner has assessed the client;
(2) the diagnosis, goals, treatment interventions and discharge plan are appropriate;
(3) the supervising practitioner has reviewed the plan with the therapist and is directing this plan; AND
(4) the care is appropriate medically necessary active treatment.

(Date of signature is the date the treatment plan is approved and matches Item 9.)

A stamped signature is not acceptable. Signature and date must be legible.

Item 33: Client signature and date. This signature indicates the client participated in developing this treatment plan.

Distribution and Retention: The original copy of the treatment planning document or Form MC-83 is retained by the provider in the client's clinical record for five years. It is not necessary to submit a copy of Form MC-83 with Medicaid claims.

To view printable form click here: MHSA Treatment Planning Document for Outpatient Services

Nebraska Department of Health & Human Services

MHSA Treatment Planning Document for Outpatient Services

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

1. Client Name	2. Client Medicaid Number	3. Initial ☐ Update ☐	4. Sex ☐ Male ☐ Female	5.Age

6. Health Check Date	7. Pre-Treatment Assessment Date	8. Initial Dx Interview Date	9. Date This Report	10. Onset Date, Current Acute Symptoms

11. CURRENT ACTIVE SYMPTOMS & FUNCTIONAL IMPAIRMENTS (Updated with each Treatment Plan Review) ☐

12. Associated Medical, Legal, Social, Educational, Occupational or Other Problems ☐

13. Consultations (Date & Name) ☐

Diagnosis (Code & Narrative)

14. Axis I

15. Axis II	17a. Axis IV
16. Axis III	17b. Axis V

18. PROGESS OR COMPLICATIONS SINCE LAST REPORT & CLIENT'S PARTICIPATION IN TREATMENT (Narrative) ☐

19. Short Term Goals (Expected Outcome in 30 - 90 days) ☐

20. Long Term Goals (Expected Outcome in 90 days - 1 year) ☐

Treatment Prescribed (Frequency, Name & Title of Provider)

21. Individual Therapy	22. Group Therapy (Group Name)

23. Family Therapy (list family members involved)

24. Conferences	25. Date of Previous Medication Check	Medication Checks Only? ☐ YES ☐ NO

26. Community Treatment Aide Services

27. Medications (Name, Dosage, and Frequency)

Discharge Planning

28a. Estimated Length of Treatment	28b. Targeted Number of Sessions	28c. Targeted Discharge Date

29. Discharge Plan ☐

30. Provider Name	31. Medicaid Provider Number

32. I certify that this active treatment is medically necessary at this level of care. (Signature & Date must be handwritten.)

SIGNATURE OF SUPERVISING PRACTITIONER | Title | Date of Signature

Print or Type Name of Supervising Practitioner

33. I participated in the development of my treatment plan.

Client's Signature | Date of Signature