67:16:41:06. Treatment plan requirements. The mental health provider must develop a treatment plan for each recipient who is receiving medically necessary covered mental health treatment based on a primary diagnosis of a mental disorder. The plan must be relevant to the diagnosis, be developmentally appropriate, and relate to each covered mental health treatment to be delivered.

The treatment plan must meet all of the following requirements:

- (1) Be developed jointly by the recipient, or legal guardian, and the mental health provider who will be providing the covered mental health treatment;
 - (2) Include a list of other professionals known to be involved in the case;
- (3) Contain written objectives which specifically address the recipient's individual treatment goals;
- (4) Be based on the findings of the diagnostic assessment and contain the recipient's mental disorder diagnosis code;
 - (5) List the specific therapies and activities prescribed for meeting the treatment goals;
- (6) Include the specific treatment goal for improving the recipient's condition to a point of no longer needing mental health treatment; and
- (7) Include a specific schedule of treatment services including the prescribed frequency and duration of each mental health service to be provided to meet the treatment plan goal.

The mental health provider must complete, sign, and date the treatment plan before the fourth face-to-face session with the recipient. The signature is a certification by the mental health provider that the treatment plan is accurate. The certification date is the effective date of the treatment plan.

Mental health treatment provided after the third face-to-face session with the recipient without a supporting treatment plan meeting the requirements of this section is not covered.

Source: 22 SDR 6, effective July 26, 1995; 37 SDR 53, effective September 23, 2010.

General Authority: SDCL 28-6-1. **Law Implemented:** SDCL 28-6-1.

Cross-Reference: Clinical record requirements, § 67:16:41:08.