



MENTAL HEALTH BULLETIN

COMMONWEALTH OF PENNSYLVANIA

DEPARTMENT OF PUBLIC WELFARE

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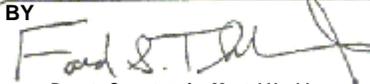
NUMBER

5221-93-01

SUBJECT

Intensive Case Management
Record Requirements

BY


Deputy Secretary for Mental Health

SCOPE:

County HH/MR Administrators
Intensive Case Management Providers

PURPOSE:

The purpose of this Bulletin is to provide direction and clarification on the content of an intensive case management record.

BACKGROUND:

The Intensive Case Management Regulations (55 PA Code Chapter 5221) established standards for intensive case management records in §5221.31.(4), Responsibilities of Providers, and §5221.41, Recordkeeping. However, intensive case management providers have asked for more explicit guidelines on record content. In addition, since the Office of Mental Health is not requiring the use of the Intensive Case Management Program Service Documentation Form (MH-794) as of July 1, 1993, counties and providers have asked for guidance in documenting service delivery. The Office of Mental Health is providing these guidelines to help providers avoid unnecessary paperwork while conforming to the regulatory requirements.

Medical Assistance reimbursed services are subject to the general provisions of the Medical Assistance Program, unless otherwise stated. Since intensive case management is not a medical service, compliance with §1101.51(d) is not required.

CLARIFICATION:

In order to satisfy the recordkeeping requirements established in §5221.31 (4) and §5221.41, intensive case management records should contain, at a minimum, the following:

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

Your OMH Area Director

- (iii) Identifies specific goals, objectives, responsible person(s) timeframes for completion and the ICM's role in relating to the consumer and involved others.
- (iv) Is signed by the consumer, the family if the consumer is a child, the ICM, the ICM Supervisor and others as determined appropriate by the consumer and ICM. If the signature(s) cannot be obtained, attempts. To obtain them should be documented.

(4) Documentation of Services

- (i) Case Notes
 - (A) Are legible.
 - (B) Verify the necessity for the contact and reflect the goals and objectives of the ICM service plan.
 - (C) Include the date, time and Circumstance of al contacts, regardless of whether or not a billable service was provided.
 - (D) Identify the consumer by name or case number on both sides of each page on which there is writing on both sides (name and, case number should appear together earlier in the file).
 - (E) Are dated and signed by the individual providing the service.
- (ii) Documentation of referral for other services.
- (iii) Encounter Forms.

(5) Discharge Information

- (i) Termination summary, including reason for admission to ICM, services provided, goals attained, goals not completed and why and reason for closure.
 - (A) Contains signature of the consumer, the family if the consumer is a child, and involved others (if obtainable) to verify agreement of the termination.
 - (B) Contains the signature of the County Administrator or designee if the consumer and family, if the consumer is a child, do not consent to termination.
- (ii) Recommended after-care plan.

Statement of Policy

512.41 a INTENSIVE CASE MANAGEMENT RECORD REQUIREMENTS

(1) Intake Information

- (i) Identifying information to include the consumer's name, address, date of birth, social security number, and third party resources.
- (ii) Referral Form, to include date, source and reason for referral to ICM and DSM III-R (or subsequent revision) diagnosis.
- (iii) Verification of eligibility to receive ICM (such as past treatment records, psychiatric or psychological evaluation, letter summarizing treatment history, Individual Education Plan, etc.).

(2) Assessments and Evaluations

- * (i) Medical history, taken within the past 12 months, or documentation of the ICMs efforts to assist the consumer in obtaining a physical examination.
- (ii) Assessment of the consumer's strengths, needs and interests.
- * (iii) Summaries of hospitalizations, incarcerations, or other out of home placements while enrolled in ICM including the place and date of admission, the reason for admission, length of stay and discharge plan.
- * (iv) Children only – IEP, school testing (e.g., psychological evaluations), guidance counselor reports, etc., or documentation of the ICM's efforts to obtain the information if not in the record.
- (v) Outcome information required for annual CCRS reporting (Consumer Level of Functioning, Independence of Living and Vocational/Educational Status).

* **NOTE:** If the ICM provider is part of a multiple service agency which maintains the above * assessments and evaluations in another file, the information other than that required to establish eligibility for ICM does not need to be duplicated for the ICM record. However, these reports are considered to be part of the ICM record, and must be made available if the ICM record is requested.

(3) Written Service Plan

- (i) Initial plan is developed within 1 month of registration and reviewed at least every 6 months.
- (ii) Reflects documented assessment of consumer's strengths and needs.