



ADMINISTRATIVE RULES OF MONTANA



37.106.1440 CLINICAL REQUIREMENTS

- (1) Each client must have an individualized treatment plan (ITP) developed by an interdisciplinary treatment team.
- (2) ITPs must include:
 - (a) the client's name, diagnoses, treatment plan date, and treatment plan review dates;
 - (b) the names of treatment team members who are involved in the client's treatment;
 - (c) the individualized client strengths;
 - (d) the problem area(s) that will be the focus of treatment to include symptoms, behaviors, and/or functional impairments;
 - (e) the treatment goals, objectives, and interventions that are person centered and recovery oriented;
 - (f) the description of the type, duration, and frequency of the intervention(s) and services(s);
 - (g) expected dates of completion;
 - (h) an educational plan for youth; and
 - (i) the client's level of functioning that will indicate when a service is no longer required.
- (3) ITPs and treatment plan reviews must be completed with the client and include the client's legal guardian and at least one qualified licensed professional. The treatment plan and treatment plan reviews must be signed and dated by interdisciplinary team members, the client, and the client's legal guardian (if applicable).
 - (a) Additional service providers must be contacted and encouraged to participate as clinically indicated.
- (4) ITPs must be completed within:
 - (a) 24 hours of admission for ASAM 3.7, 3.7-WM and 3.2-WM;
 - (b) 48 hours of admission for ASAM 3.5;
 - (c) seven days of admission for ASAM 3.3 and 3.1; and
 - (d) five contacts or 21 days from the first contact, whichever is later, for outpatient facilities.
- (5) Treatment plan reviews must be completed:
 - (a) every three days from the admission date for ASAM 3.7, 3.7-WM and 3.2-WM.

- (b) every seven days from the admission date for ASAM 3.5;
 - (c) every 30 days from the admission date for ASAM 3.1;
 - (d) every 14 days from the admission date for ASAM 2.5; and
 - (e) every 90 days from the admission date for outpatient facilities.
- (6) Treatment plan reviews must include:
- (a) documentation regarding the client's response to treatment;
 - (b) review of the client's progress in all six dimensions; and
 - (c) progress towards goals and objectives that result in either an amended ITP or a statement of the continued appropriateness of the existing plan.
- (7) A continuing care plan must be given to the client and, if applicable, the client's legal guardian/parent, representative or guardian at the time of discharge and must include, if applicable:
- (a) client's name, date of birth, admission and discharge dates, and reason for placement and discharge;
 - (b) a written summary of services provided, including the client's participation and progress in the SUDF, contact information of licensed health care providers who conducted evaluations and treatment, and condition of the client at the time of discharge;
 - (c) goals for continuing care and recovery;
 - (d) community substance use treatment provider's contact name, contact number, and time and date of an initial appointment;
 - (e) health care follow-up including provider's contact name, contact number, and initial appointment (if necessary);
 - (f) current medications, dosage taken, number of times per day, and name of prescribing licensed health care professional;
 - (g) name and contact number of the client's recovery supports;
 - (h) housing and employment plan;
 - (i) medical, dental, and psychiatric care received during placement;
 - (j) adolescent's educational status (if applicable); and
 - (k) signature of the client and of the staff member who prepared the plan.

Authorizing statute(s): 50-5-103, 53-24-208, MCA

Implementing statute(s): 50-5-101, 50-5-103, 53-24-207, 53-24-208, 76-2-411, MCA

History: NEW, 2010 MAR p. 2975, Eff. 12/24/10; AMD, 2022 MAR p. 1889, Eff. 9/24/22.