A-1641

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§482.61(c)(1)(i) The written plan must include—A substantiated diagnosis;

Interpretive Guidelines §482.61(c)(1)(i)

The substantiated diagnosis serves as the basis for treatment interventions. A substantiated diagnosis is the diagnosis identified by the treatment team to be the primary focus upon which treatment planning will be based. It evolves from the synthesis of data from various disciplines.

At the time of admission, the patient may have been given an initial diagnosis or a rule-out diagnosis. At the time of treatment planning, a substantiated diagnosis must be recorded. It may be the same as the initial diagnosis, or, based on new information and assessment, it may differ.

Rule-out diagnoses, by themselves are not acceptable as a substantiated diagnosis.

Data to substantiate the diagnosis may be found in, but is not limited to, the psychiatric evaluation, the medical history and physical examination, laboratory tests, medical and other psychological consults, assessments done by disciplines involved in patient evaluations and information supplied from other sources such as community agencies and significant others.

Survey Procedures §482.61(c)(1)(i)

What specific problems will be treated during the patient's hospitalization?

Does the treatment plan identify and precisely describe problem behaviors rather than generalized statements i.e., “paranoid,” “aggressive,” “depressed?” or generic terminology i.e., “alteration in thought process,” “ineffective coping,” “alteration in mood?”
Are physical problems identified and included in the treatment plan if they require treatment, or interfere with treatment, during the patient’s hospitalization?