Title 23: Division of Medicaid

Part 206: Mental Health Services

Part 206 Chapter 2: Mississippi Youth Programs Around the Clock (MYPAC)

Rule 2.1: Purpose

A. The purpose of Mississippi Youth Programs Around the Clock (MYPAC) services is to provide home and community-based services to beneficiaries up to the age of twenty-one (21) with serious emotional disturbance (SED) that:

1. Exceed the resources of a single agency or service provider,

2. Experience multiple acute hospital stays,

3. Have been recommended for residential care,

4. Have had interruptions in the delivery of services across a variety of agencies due to frequent moves, failure to show improvement, lack of previous coordination by agencies providing care, or reasons unknown,

5. Are at immediate risk of requiring treatment in a Psychiatric Residential Treatment Facility (PRTF), or

6. Are receiving services in a PRTF and are ready to transition back to the community.

B. The Division of Medicaid defines MYPAC services as all-inclusive home and community based services that assist beneficiaries and their families in gaining access to needed mental health services as well as medical, social, educational and other services regardless of the funding source for those other services and includes service coordination that involves finding and organizing multiple treatment and support services.

Source: Miss. Code Ann. §§ 43-13-117(46), 43-13-121, 43-14-1; Public Law 99-660 (1986), 101-639 (1990), 102-321 (1992); OBRA Section 4755.

History: Revised to correspond with SPA 2012-003 (eff. 07/01/2012) eff. 12/01/2013.

Rule 2.2: Eligibility

A. Beneficiaries must meet clinical and age criteria to receive MYPAC services.

1. The Utilization Management and Quality Improvement Organization (UM/QIO) for the Division of Medicaid reviews and prior authorizes the provision of services based on all the following clinical criteria. A beneficiary:

a) Must be diagnosed by a psychiatrist or licensed psychologist in the past sixty (60) days with a mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria for Serious Emotional Disturbance (SED) specified within the Diagnostic and Statistical Manual (DSM) on Axis I,

b) Must have a full scale IQ of sixty (60) or above, or, if IQ score is lower than sixty (60), there is substantial evidence that the IQ score is suppressed due to psychiatric illness, and

c) Is currently a resident of a PRTF or acute care facility who continues to meet the LOC for residential treatment but can be transitioned into the community with MYPAC services or meets the same level of care (LOC) for admission to a PRTF but can be diverted to MYPAC as an alternative to residential treatment.

2. A beneficiary must be admitted prior to his/her twenty-first (21st) birthday; however, if a beneficiary is already receiving MYPAC services prior to age twenty-one (21), he/she may remain in MYPAC until treatment is completed or the beneficiary's twenty-second (22nd) birthday, whichever occurs first.

B. MYPAC services are provided to eligible beneficiaries under the:

1. 1915(c) demonstration waiver, which enrollment ended on September 30, 2012, per Centers for Medicare and Medicaid Services (CMS), or

2. State Plan Rehabilitation Option Intensive Outpatient Psychiatric Services.

Source: Miss. Code Ann. §§ 43-13-117(46), 43-13-121, 43-14-1; 42 CFR §§ 441, Subpart D, 483.352; 42 USC 1396a(a)(10)(A); OBRA Section 455.

History: Revised to correspond with SPA 2012-003 (eff. 07/01/2012) eff. 12/01/2013.

Rule 2.3: Provider Participation Requirements

A. Providers of MYPAC services must satisfy all requirements set forth in Part 200, Chapter 4, Rule 4.8.

B. MYPAC service providers must also meet the following provider specific requirements:

1. Submit a completed proposal package and enter into a provider agreement with the Division of Medicaid to provide services under the State Plan Rehabilitation Option Intensive Outpatient Psychiatric Services.

2. Provide MYPAC services by mental health providers who meet the Mississippi Department of Mental Health (DMH) certification requirements.

3. Have a current Medicaid provider number.

4. Hold certification by DMH to provide:

    a) Case management services under the 1915(c) demonstration waiver, or

    b) Wraparound facilitation services under the State Plan Rehabilitation Option Intensive Outpatient Psychiatric Services.

5. Have a psychiatrist on staff.

6. Have appropriate clinical staff to provide needed therapy services.

7. Provide the Division of Medicaid with a written description of any critical incidents as well as staff interventions, responses and management of the critical incident. A critical incident is an occurrence or situation that creates a significant risk or serious harm to the physical or mental health, safety or well-being of a beneficiary including, but not limited to life-threatening events, allegations of staff misconduct, or abuse/neglect.

8. Inform the beneficiary/family of grievances and appeals procedures.

9. Report all grievances and appeals to the Division of Medicaid.

10. Employ staff who meets the Division of Medicaid qualifications for the category of service they provide.

11. Conduct Quality Assurance activities to regularly review each beneficiary's Individualized Service Plan (ISP) and treatment outcomes.

12. Have procedures in place for availability and response twenty-four (24) hours a day, seven (7) days a week.

13. Notify the Division of Medicaid of changes in the Administrative/Program Director, Medical Director/Psychiatrist or Clinical Director, and Regional Supervisor within seventy-two (72) hours of the effective change.

Source: Miss. Code Ann. §§ 43-13-117, 43-13-118, 43-13-121, 43-13-129; 42 CFR §§ 441, Subpart D, 441.151(a)(2).

History: Revised to correspond with SPA 2012-003 (eff. 07/01/2012) eff. 12/01/2013.

Rule 2.4: MYPAC Service Requirements

A. The Division of Medicaid covers one hundred fifteen (115) units during a three hundred and sixty-five (365) day period of MYPAC services.

B. MYPAC services include, but are not limited to:

1. Mental health services using evidence-based practices which include intensive in-home therapy, crisis outreach, medication management and psychiatric services,

2. Social services to ensure basic needs are met, provide family support, and develop age appropriate independent living skills.

3. Physical health and welfare services that include assistance to the family in obtaining screenings from the Early Periodic Screening, Diagnosis, and treatment (EPSDT) services.

4. Educational and/or vocational services to assist with school performance and/or provide support for employment,

5. Recreational activities to identify skills and talents, enhance self-esteem, and increase opportunities for socialization, and

6. Other supports and services as identified by the beneficiary, family, and child and family team.

C. MYPAC providers are required to provide or arrange for the provision of wraparound facilitation defined as the creation and facilitation of a child and family team for the purpose of developing a single individual service plan (ISP) to address the needs of the beneficiary with complex mental health challenges and their families. Wraparound facilitation must be provided in accordance with high fidelity and quality wraparound practice and include the following:

1. Engaging the family,

2. Assembling the child and family team which includes:

   a) The wraparound facilitator,

   b) The beneficiary's service providers, any involved beneficiary serving agency representatives and other formal supports, as appropriate,

   c) The caregiver/guardian,

   d) Other family or community members serving as informal supports, as appropriate, and

   e) Other identified youth, unless there are clear clinical indications this would be detrimental which are documented clearly throughout the medical record.

3. Facilitating the child and family team meeting, at a minimum, once a month,

4. Facilitating the development of an ISP through decisions made by the child and family team during the child and family team meeting, including a plan for anticipating, preventing and managing crisis,

5. Working with the child and family team in identifying providers of services and other community resources to meet the family and beneficiary's needs,

6. Making necessary referrals for beneficiaries,

7. Documenting and maintaining all information regarding the ISP, including revisions and child and family team meetings,

8. Presenting ISP for approval to the child and family team,

9. Providing copies of the ISP to the entire team including the beneficiary and family/guardian,

10. Monitoring the implementation of the ISP and revising as necessary to achieve outcomes,

11. Maintaining communication between all child and family team members,

12. Evaluating the progress toward needs being met to ensure the referral behaviors have decreased,

13. Leading the child and family team to discuss and ensure the supports and services continue to meet the caregiver and the beneficiary's needs,

14. Educating new team members about the wraparound process,

15. Maintaining team cohesiveness,

16. Meeting face-to-face with a MYPAC beneficiary once a week,

17. Meeting face-to-face with the family twice a month,

18. Meeting with other collateral contacts related to ISP implementation at least three (3) times a week, and

19. Ensuring MYPAC beneficiaries on medication(s) used in the treatment of the beneficiary's SED visit a doctor every ninety (90) days for medication management and monitoring, at a minimum.

D. Intensive case management is provided to beneficiaries in MYPAC only under the 1915(c) Demonstration waiver and is defined by the Division of Medicaid as services that assist MYPAC participants and families in gaining access to needed mental health services, as well

as medical, social, educational and other services, regardless of the funding source for the services in which access is gained and includes service coordination that involves finding and organizing multiple treatment and support options. Refer to the Rule 2.2.B.1.

E. Respite care is provided to MYPAC beneficiaries only under the 1915(c) demonstration waiver and is defined by the Division of Medicaid as a planned break for families to give the parent/caregiver temporary relief from caregiving. Refer to the Rule 2.2.B.1. The two (2) types of respite care are:

1. In-home, or home and community-based respite care provided by responsible adults or trained counselors, and

2. Out-of-home or institutional respite care provided by direct clinical staff in a PRTF or short-term treatment and crisis stabilization in an inpatient psychiatric hospital.

F. MYPAC staff must be appropriately trained or professionally qualified to provide services for which they are responsible.

1. A psychiatrist:

a) Must participate in the development of the ISP and is a child and family team member.

b) Is responsible for medication management, which is defined by the Division of Medicaid as medication treatment and monitoring services which include the prescription of psychoactive medications by a physician/psychiatrist that are designed to alleviate symptoms and promote psychological growth and includes:

1) Prescribing medication(s) to treat SED,

2) Educating the child and family_team concerning the effects, benefits, and proper use and storage of any medication prescribed for the treatment of SED,

3) Assisting with the administration or monitoring of the administration, of any medication prescribed for the treatment of SED, and

4) Arranging for any physiological testing or other evaluation necessary to monitor the participant for adverse reactions to, or for other health-related issues that might arise in conjunction with, the taking of any medication prescribed for the treatment of SED.

c) Must be in a practice agreement with and supervise any licensed/certified Psychiatric Mental Health Nurse Practitioner (PMHNP) who assists with their responsibilities.

d) Must meet face-to-face or by telepsychiatry with the beneficiary and family at the frequency documented in the ISP.

2. A master's level mental health therapist who:

    a) Provides psychotherapy defined by the Division of Medicaid as the intentional, face-to-face interaction between a mental health professional and a beneficiary which establishes a therapeutic relationship to resolve symptoms of the beneficiary's mental and/or emotional disturbance.

    b) MYPAC psychotherapy includes the following:

        1) Family Therapy is defined by the Division of Medicaid as psychotherapy between a mental health therapist and a beneficiary's family members or guardians, with or without the presence of the beneficiary, and

            i) Promotes psychological and behavioral changes within families and meets on a regular basis.

            ii) Can include Department of Human Services (DHS) representatives or foster family members, acting in loco parentis, for beneficiaries in the custody of the DHS,

        2) Group Therapy is defined by the Division of Medicaid as psychotherapy between a mental health therapist and at least two (2), but no more than eight (8), individuals at the same time, and promotes psychological and behavioral changes with groups typically meeting on a regular basis and includes, but not limited to, focusing on relaxation training, anger management and/or conflict resolution, social skills straining and self-esteem enhancement.

        3) Individual Therapy is defined as psychotherapy that takes place between a mental health therapist and a beneficiary reliant upon interaction between therapist/clinician and beneficiary to promote psychological and behavioral change.

3. Wraparound Facilitators who:

    a) Are identified as only one (1) MYPAC provider staff for each beneficiary and family and ensures appropriate coordination of services are identified and accessed.

    b) Facilitates the development of the ISP through decisions made by the wraparound team.

    c) Facilitates the child and family team meetings and assures all team members have the opportunity to participate.

    d) Assists the beneficiary and family team in identifying goals and interventions based on the strengths and needs of the child and family.

e) Ensures needed resources are in place for the family.

f) Receives training to identify different levels of intervention on an Individualized Crisis Management Plan (ICMP), the different stages of crisis, and how a crisis may be defined differently by each family.

g) Accesses and links identified services to the beneficiary and family which must be completed before the beneficiary is discharged from MYPAC in order to achieve a successful transition.

h) Available twenty-four (24) hours a day, seven (7) days a week to a beneficiary and family for assistance.

i) Has completed the Introduction to Wraparound Three (3)-day training.

j) Must participate in ongoing coaching and training as defined by the Division of Medicaid or its designee.

4. A Wraparound Facilitator supervisor who:

a) Has completed the Introduction to Wraparound three (3)-day training,

b) Must participate in ongoing coaching and training as required by the Division of Medicaid, and

c) Supervises staff providing services to beneficiaries and families a minimum of four (4) hours of clinical supervision per month provided through a combination of individual supervision, group supervision, peer consultation and participation in wraparound meetings. Documentation must clearly identify the supervision component.

5. A Provider Organization providing wraparound facilitation which:

a) Must participate in the wraparound certification process through the Division of Medicaid or its designee, and

b) Must ensure the wraparound facilitator's case load does not exceed ten (10) cases.

Source: Miss. Code Ann. §§ 43-13-117(16), 43-13-117(46), 43-13-121, 43-14-1; 42 CFR §§ 441, Subpart D, 441.151(a)(2).

History: Revised to correspond with SPA 2012-003 (eff. 07/01/2012) eff. 12/01/2013.

Rule 2.5: Individual Service Plans (ISP)

A. For the purpose of this rule, an ISP may be referred to as the treatment plan, wraparound plan, or case management plan depending on the service which directs the treatment of the beneficiary.

B. The Division of Medicaid defines the ISP as a written, detailed document that is integral to the wraparound process and is beneficiary/family driven. An ISP must be developed by the child and family team, and is individualized for each MYPAC beneficiary.

1. The ISP must include the following:

a) Services to be provided,

b) Frequency of service provision,

c) Staff providing each service and their qualifications,

d) Formal and informal supports available to the beneficiary and family, and

e) Plans for anticipating, preventing and managing crises.

2. Each ISP must include an Individualized Crisis Management Plan (ICMP) which:

a) Is developed during the child and family team meeting based on the individualized preferences of the beneficiary and family.

b) Identifies triggers that may lead to potential crisis or risk and interventions and strategies to mitigate the risk that can be implemented to avoid the crisis.

c) Identifies natural supports that may decrease the potential for a crisis to occur.

d) Identifies specific needs of families and tailors the level of intervention.

e) Provides responses that are readily accessible at any time to the beneficiary and family.

f) Contains contact information for those involved at all levels of intervention during the crisis.

g) Provides for crisis debriefing after the crisis has been resolved.

h) Provides a copy of the ISP, ICMP and contacts to the beneficiary and family.

3. The wraparound facilitator monitors the ISP continuously through face-to-face visits with the beneficiary and family.

a) The child and family team reviews the ISP at least every thirty (30) days through a child and family team meeting.

b) The ISP is updated or revised when warranted by changes in the beneficiary's needs.

c) The full child and family team must participate in the development of the initial ISP, revisions of the ISP, and the discharge ISP.

d) A licensed clinical staff member must attend each child and family team meeting and is responsible for submitting the ISP to the psychiatrist for review following the meeting at least every ninety (90) days.

Source: Miss. Code Ann. §§ 43-13-117(46), 43-13-121, 43-14-1; 42 CFR § 441, Subpart D.

History: Revised to correspond with SPA 2012-003 (eff. 07/01/2012) eff. 12/01/2013.

Rule 2.6: Clinical Documentation Requirements

A. Beneficiary records must be complete, accurate, accessible and organized.

1. Clinical documents must include begin time and end time for each contact.

2. Records must be maintained for a period of five (5) years after the beneficiary reaches the age of twenty-one (21).

3. Refer to Maintenance of Records Part 200, Chapter 1, Rule 1.3.

B. Records must contain the following categories:

1. Administrative Documentation must include:

a) Demographic information that includes date of birth, gender, and race,

b) Copy of the participant's birth certificate and/or social security card,

c) Copy of any legal documents verifying custody or guardianship of the beneficiary, when the responsible party is anyone other than the beneficiary's legal parent(s),

d) Name, address and phone number of the party bearing legal responsibility for the beneficiary should be clearly identified, along with his/her relationship to the beneficiary,

e) Assigned county of custody and the caseworker identified as an agent of DHS if the beneficiary is in the custody of DHS, and

f) Documents signed and dated by the beneficiary and/or family that inform them of:

1) Beneficiary's rights and responsibilities,

2) Consent for treatment,

3) Complaints and grievances procedures, and

4) Appeals and right to fair hearing.

2. Assessments must include:

a) Independent psychiatric or psychological evaluation and IQ testing.

b) Bio-psychosocial assessment that includes:

1) Developmental profile,

2) Behavioral assessment,

3) Assessment of the potential resources of the beneficiary's family,

4) Medical history,

5) Current educational functioning, and

6) Family and beneficiary strengths and needs

3. Treatment Planning must include:

a) ISP signed and dated by the child and family team and in place within fourteen (14) days of enrollment in MYPAC, and reviewed with wraparound team every thirty (30) days,

b) ICMP included in the ISP,

c) Documentation treatment planning is occurring in the child and family team meetings, and

d) Treatment Planning is directed by the MYPAC beneficiary and family.

4. Services provided must include:

a) Wraparound facilitation progress notes which document:

1) The relationship of services to identified needs of family and beneficiary as stated in the ISP,

2) Detailed narration from face-to-face meetings with the beneficiary and/or family, or collateral contacts, including setting, crisis, barriers and successes, and

3) Date and signature of wraparound facilitator.

b) Child and family team meeting notes which document:

1) The purpose and results of services provided that are consistent with the needs outlined in the ISP,

2) Changes to ISP, including dates and reason for changes,

3) Treatment successes,

4) Implementation of the ICMP and outcome, if used,

5) Names and positions or roles of each team member, and

6) Dates and signatures of participating team members.

c) Medication management and monitoring documentation must include:

1) Evidence the treating psychiatrist has managed all beneficiary SED medication(s) at least every ninety (90) days, including but not limited to, reviewing, revising, adjusting, discontinuing and monitoring.

2) If the family chooses a different physician to prescribe medication(s) used in the treatment of the beneficiary's SED, the psychiatrist employed by the MYPAC provider as Medical Director must provide feedback on the implementation of the ISP.

3) Medication(s) to treat the beneficiary's SED are accurately administered by the family in accordance with the physician or PMHNP's orders.

4) Informed consent for medication(s) used in the management of the beneficiary's SED is signed by the parent/guardian and beneficiary, if age appropriate, identifying the symptoms the medications target and evidence education has been provided.

5) Effectiveness of medication(s) to treat the beneficiary's SED.

6) Current medication(s) to treat the beneficiary's SED as reflected in the medication profile sheet.

7) Assistance to family with obtaining, administering and monitoring any medication(s) prescribed for the treatment of the beneficiary's SED.

8) Assessment for side effects of medication(s) to treat beneficiary's SED including physiological testing or other evaluations necessary to monitor for adverse reactions or other health related issues that might arise from taking medication(s) to treat beneficiary's SED.

9) Regular monitoring of medication(s) to treat the beneficiary's SED by the MYPAC provider and reporting any inconsistencies to the treating psychiatrist.

d) Psychotherapy notes must include:

1) Date of session,

2) Time session began and time session ended,

3) Specify if therapy is individual, family or group,

4) Person(s) participating in session,

5) Clinical observations about the beneficiary and/or family, including demeanor, mood, affect, mental alertness, and thought processes,

6) Content of the session,

7) Therapeutic interventions attempted and beneficiary/family's response to the intervention,

8) Beneficiary's response to any significant others who may be present in the session,

9) Outcome of the session,

10) Statement summarizing the beneficiary and/or family's degree of progress toward the treatment goals,

11) Signature, credentials and printed name of therapist, and

12) Notes for each session. Monthly summaries are not acceptable in lieu of psychotherapy session notes.

5. Discharge planning documentation must include:

a) Discharge planning began the first (1st) day of admission.

b) Discharge planning is done with the beneficiary and family through the wraparound process.

c) A signed copy of the final discharge plan with signatures of the MYPAC beneficiary and caregiver/guardian at the time of discharge.

Source: Miss. Code Ann. §§ 43-13-117, 43-13-118, 43-13-121, 43-13-129; 42 CFR § 441, Subpart D.

History: Revised to correspond with SPA 2012-003 (eff. 07/01/2012) eff. 12/01/2013.

Rule 2.7: Special Procedures

A. The use of special procedures, including restraints or seclusion, for participants in a community setting is prohibited.

B. If a participant enrolled in MYPAC is admitted to a PRTF for respite under the 1915(c) demonstration waiver, Medicaid rules and State and Federal regulations must be followed. Refer to Part 207, Chapter 4.

Source: Miss. Code Ann. § 43-13-121; 42 CFR §§ 441. Subpart D, 483, Subpart G.

History: Revised to correspond with SPA 2012-003 (eff. 07/01/2012) eff. 12/01/2013.

Rule 2.8: Discharge/Transition Planning

A. For all beneficiaries receiving MYPAC services, discharge planning must begin at the time of admission and the MYPAC provider is responsible for assisting the family with transition plans through the wraparound process.

B. The wraparound facilitator must access and link appropriate services to the beneficiary and family prior to discharge from MYPAC services.

C. Discharge from MYPAC services occurs when the beneficiary ;

1. Reaches twenty-two (22) years of age or “ages out”,

2. If applicable, or family utilizes their freedom of choice to end MYPAC services,

3. Moves out of state,

4. No longer meets the criteria or needs the intensity of services provided by MYPAC, or

5. Admits to an acute care facility or PRTF.

D. At the time of the beneficiary's discharge from MYPAC services, the discharge/transition plan should be amended to include any of the following, if there is a change:

1. MYPAC services begin and end date,

2. Reason for discharge,

3. The name of the person or agency that cares for and has custody of the beneficiary,

4. The physical location/address where the beneficiary resides,

5. A list of the beneficiary's diagnoses,

6. Detailed information about the beneficiary's prescribed medication(s) to treat the beneficiary's SED including the names, strengths and dosage instructions in layman's language and any special instructions, including but not limited to, lab work requirements,

7. Information connecting the beneficiary and family with community resources and services, including but not limited to:

    a) Address of where follow-up mental health services will be obtained with contact name and phone number.

    b) Name and address of the school the beneficiary will attend with name and contact information of identified educational staff.

    c) Other recommended resources, including recreational, rehabilitative, or other special programs including the corresponding contact information.

    d) Date, time, and location of any scheduled appointments.

8. Detailed and specific recommendations in writing about the beneficiary's participation in the MYPAC program including successful techniques in areas of behavior management, mental health treatment and education, and

9. The offer of a full array of community-based mental health services for beneficiaries.

E. At the time of the beneficiary's discharge from MYPAC, the provider must give the parent/guardian:

1. A written copy of the final discharge plan, and

2. A written prescription for a thirty (30) day supply of all medications used for the management of the beneficiary's SED if the current supply does not exceed thirty (30) days.

F. The provider must obtain signed consent from the beneficiary and family to provide copies of the final discharge plan to the providers of follow-up mental health, education and other agreed-upon services to be provided after discharge.

Source: Miss. Code Ann. §§ 43-13-117(46), 43-13-121, 43-14-1; 42 CFR 441, Subpart D.

History: Revised to correspond with SPA 2012-003 (eff. 07/01/2012) eff. 12/01/2013.

Rule 2.9: Grievances, Appeals and Fair Hearings

A. The Division of Medicaid defines grievances as a complaint filed about unfair treatment.

1. MYPAC providers must:

a) Maintain records of all grievances received,

b) Track grievances and responses, and

c) Establish a grievance system that includes written policies and procedures,

2. MYPAC providers must report to the Division of Medicaid:

a) All grievances by beneficiaries and/or family members or third parties on behalf of beneficiaries within two (2) business days of receipt, and

b) Submit a quarterly summarization of each grievance, either on-going or resolved, reported during the quarter.

B. The Division of Medicaid defines an appeal as a formal request to change an adverse decision by the MYPAC provider who must:

1. Have a written appeal process with policies and procedures which includes a Notice of Action defined as a notification to the beneficiary/family within ten (10) days before the date of termination, suspending or reducing any services by the MYPAC provider,

2. Forward any formal appeal requests including the Notice of Action to the Division of Medicaid within two (2) business days of receipt,

3. Submit a quarterly report to the Division of Medicaid summarizing each appeal, either on-going or resolved, that was received during the quarter, and

4. Participate, at the provider's sole expense, in any review, appeal, fair hearing or litigation involving issues related to MYPAC at the request of the Division of Medicaid.

C. The Division of Medicaid defines a fair hearing as a process initiated when a beneficiary or family disagrees with an adverse decision following an appeal to the MYPAC provider.

1. The beneficiary or family must request an appeal and receive an adverse decision from the provider prior to requesting a fair hearing.

2. Refer to Part 300 Appeals, Chapter 1: Appeals, Rule 1.3: Administrative Hearings for Beneficiaries.

Source: Miss. Code Ann. § 43-13-121; 42 CFR §§ 438 Subpart F, 431 Subpart E.

History: Revised to correspond with SPA 2012-003 (eff. 07/01/2012) eff. 12/01/2013.

Rule 2.10: Critical Incidents Occurrences

A. The Division of Medicaid defines critical incidents as any occurrence that results in injury, abuse, neglect or exploitation of a MYPAC beneficiary. MYPAC providers must have written policies for documenting and reporting all critical incidents/occurrences which must include the following:

1. Reporting of critical incidents in writing within one (1) business day to the Division of Medicaid.

2. Reporting any suspected abuse or neglect to the Mississippi Department of Human Services (DHS) and participate in investigations.

3. A written description of events and actions.

4. Documentation that explains follow-up, resolution, and debriefing.

B. Certain critical incidents that must be reported include, but are not limited to:

1. Life-threatening injuries,

2. Allegations of staff misconduct,

3. Allegations of sexual activity between MYPAC beneficiaries and providers,

4. Allegations of abuse or neglect of a beneficiary, and/or

5. Runaway of a participant.

Source: Miss. Code Ann. § 43-13-1.

History: Revised to correspond with SPA 2012-003 (eff. 07/01/2012) eff. 12/01/2013.

Rule 2.11: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of this Title, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121.

History: Added eff. 12/01/2013.