Title 23: Division of Medicaid

Part 206: Mental Health Services

Chapter 1: Community Mental Health Services

Rule 1.1: Provider Requirements

A. All providers of community mental health services must:

1. Provide proof of certification by the Mississippi Department of Mental Health (MDMH), professional license, or certification and/or license from the appropriate agency as required by the Division of Medicaid,

2. Provide proof that the services they provide have been certified by the appropriate agency when applicable,

3. Meet the applicable requirements described in Miss. Admin Code Part 200, Chapter 4,

4. Provide a National Provider Identifier (NPI), verification from the National Plan and Provider Enumeration System (NPPES), and

5. Submit written confirmation from the Internal Revenue Service (IRS) of the Provider's tax identification number and legal business name.

B. Rehabilitative services must be provided by the following licensed and enrolled providers acting within their scope of practice:

1. Board-certified or board-eligible psychiatrists licensed by the Mississippi Board of Medical Licensure.

2. Physicians licensed by the Mississippi Board of Medical Licensure acting within their scope of practice.

3. Physician Assistants (PA) must hold a Master’s degree in a health related or science field, be licensed by the Mississippi Board of Medical Licensure, and must be under the supervision of a psychiatrist or a physician.

4. Psychiatric Mental Health Nurse Practitioners (PMHNP) must hold a Master’s degree in nursing with a specialty in psychiatry, be licensed by the Mississippi Board of Nursing, and must practice within a collaborative/consultative relationship with a physician within an established protocol or practice guidelines.

5. Psychologists must hold a Ph.D. degree in psychology and be licensed by the Mississippi Board of Psychology.

6. Licensed Certified Social Workers (LCSW) must hold a Master's degree in social work and be licensed by the Mississippi State Board of Examiners for Social Workers and Marriage and Family Therapists at the LCSW level.

7. Licensed Professional Counselors (LPC) must hold a Master's degree in counseling and be licensed by the Mississippi State Board of Examiners for Licensed Professional Counselors. Provisionally Licensed Professional Counselors (P-LPCs) may provide services within the scope of their provisional license.

8. Quasi-governmental Community Mental Health Center (CMHC) agencies and private mental health centers (PMHCs) certified according to Mississippi Code Ann. § 41-4-7 by the Mississippi Department of Mental Health (DMH).

    a. DMH issues a four (4) year certification for CMHCs/PMHCs and the services provided unless stated otherwise at the time of certification.

    b. DMH certification is based on the following:

        1) Adherence to DMH standards, DMH grant requirement guidelines, contracts, memoranda of understanding, and memoranda of agreement;

        2) Compliance with DMH fiscal management standards and practices outlined in the DMH Operational Standards based on a risk-based audit system;

        3) Evidence of fiscal compliance with external funding sources;

        4) Compliance with ethical practices and codes of conduct of professional licensing entities related to provision of services and management of the organization; and

        5) Evidence of solid business and management practices.

    c. Staff qualifications for CMHC/PMHC:

        1) Qualifications for providers listed in Miss. Admin. Code Part 206, Rule 1.1.B.1. through B.8 above are applicable in CMHC/PMHC,

        2) Professional Art Therapists (ATR-BC) must hold a Master's degree in art therapy and be licensed by the Mississippi Department of Health.

        3) Registered Nurses (RN) must be a graduate from an approved or accredited RN nursing program, be licensed by the Mississippi Board of Nursing, and must be under the supervision of a psychiatrist, physician, PMHNP, or PA.

        4) Licensed Practical Nurses (LPN) must be a graduate from an approved or accredited LPN nursing program, be licensed by the Mississippi Board of Nursing and supervised by a psychiatrist, physician, PMHNP, PA or RN.

5) Licensed Marriage and Family Therapists (LMFT) must hold a Master's degree in marriage and family therapy and be licensed by the Mississippi State Board of Examiners for Social Workers and Marriage and Family Therapists.

6) DMH certifies the following staff:

(a) Certified Mental Health Therapists (CMHT), Certified Intellectual and Developmental Disabilities Therapists (CIDDT) and Certified Addiction Therapists (CAT) must hold a Master's degree in mental health, human services, intellectual disabilities, addictions, or behavioral health related fields from an approved educational institution.

(1) Provisionally certified therapists are temporarily certified while fulfilling all the certification requirements, provide the same services as a CMHT, CIDDT and CAT and must be under the supervision of certified therapist of the same discipline. Provisional certification is valid for up to twenty-four (24) consecutive months from the date of issuance.

(2) The certified credential is full certification and renewable every four (4) years as long as renewal requirements are met.

(b) Community Support Specialists must hold a minimum of a Bachelor's degree in a mental health field, be certified by DMH as a Community Support Specialist and must be under the supervision of staff listed Miss. Admin. Code Part 206, Rule in 1.1.B.1. and B.8.

(c) Peer Support Specialist Professionals must hold a minimum of a high school diploma or GED equivalent, , be certified by DMH as a Certified Peer Support Specialist and must be under the supervision of a psychiatrist, physician, PMHNP, PA, LCSW, LPC, LMFT, CMHT, CIDDT, CAT or a Peer Support Specialist Supervisor who has been trained as a Peer Support Specialist with an emphasis on supervision.

(d) Peer Support Specialist supervisors must hold a minimum of a master's degree in addictions, mental health, intellectual/developmental disabilities, or human or behavioral services field and either a 1) professional license or 2) a DMH credential as a Mental Health Therapist, Intellectual/Developmental Disability Therapist, or Addictions therapist prior to or immediately upon acceptance of a Peer Support Specialist Supervisory position and must also receive training specifically developed for Peer Support Specialist supervisors by DMH.

(e) Certified Wraparound Facilitators must hold a minimum of a bachelor's degree in a mental health, intellectual/developmental disabilities, or human services/behavioral health-related field and a DMH Community Support Specialist credential and complete the "Introduction to Wraparound" 3-day

training, be certified by DMH, and must be under the supervision of a psychiatrist, physician, PMHNP, PA, LCSW, LPC, LMFT, CMHT, CIDDT, or a CAT who has completed the "Introduction to Wraparound" 3-day training and hold a DMH High Fidelity Wraparound certificate.

7) Staff members who are provisionally certified must be supervised by a licensed professional or a credentialed DMH Certified Mental Health Therapist, DMH Certified Intellectual and Development Disabilities Therapist or DMH Certified Addiction Therapist of the same discipline.

C. Evidence–based practices (EBP) or evidence-informed best practices must be provided by a master's degree therapist who holds a professional license or DMH certification and has completed appropriate training in that evidence-based practice.

Source: 42 C.F.R. §§ 440.130, 440.169; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised and renumbered to correspond with MS SPA 20-0022 (eff. 09/01/20) eff. 11/01/2020.

Rule 1.2: Definitions

The Division of Medicaid defines:

A. Assessment as obtaining from the beneficiary, beneficiary's family or others involved in the beneficiary's care, the beneficiary's family background/ educational/vocational achievement, presenting problem(s), problem history, history of previous treatment, medical history, current medication(s), source of referral and other pertinent information in order to determine the nature of the beneficiary's or family's problem(s), the factors contributing to the problem(s), and the most appropriate course of treatment for the beneficiary.

B. Acute Partial Hospitalization as a program that provides medical supervision, nursing services, structured therapeutic activities and intensive psychotherapy (individual, family and/or group) to beneficiaries who are experiencing a period of such acute distress that their ability to cope with normal life circumstances is severely impaired. Acute Partial Hospitalization is designed to provide an alternative to inpatient hospitalization for such beneficiaries or to serve as a bridge from inpatient hospital to outpatient hospital or community treatment. Program content may vary based on beneficiary need but must include close observation/supervision and intensive support with a focus on the reduction/elimination of acute symptoms.

C. A Brief Emotional/Behavioral Health Assessment as a brief screening used to assess a beneficiary's emotional and/or behavioral health and covers a variety of standardized assessments aimed to identify the need for more in-depth evaluation for a number of mental/behavioral conditions.

D. Clinical Staff member as a staff member who holds, at a minimum, a master's degree and professional license or who is a DMH Certified Mental Health Therapist (CMHT), DMH

Certified Intellectual and Developmental Disabilities Therapist (CIDDT) or a DMH Certified Addiction Therapist (CAT) when appropriate.

E. Community Support Services as services that are specific, measurable, and individualized that focus on the beneficiary's ability to succeed in the community, to identify and access needed services, and to show improvement in school, work, and family and integration and contributions within the community and include the following as clinically indicated:

1. Identification of strengths which aid the beneficiary in their recovery and the barriers that will challenge the development of skills necessary for independent functioning in the community.

2. Individual therapeutic interventions that directly increase the acquisition of skills needed to accomplish the goals set forth in the Individual Service Plan.

3. Monitoring and evaluating the effectiveness of interventions as evidenced by symptom reduction and program toward goals.

4. Psychoeducation which includes:

   a) Identification and self-management of the prescribed medication regimen and communication with the prescribing provider.

   b) Training of family, unpaid caregivers, and/or others who have a legitimate role in addressing the needs of the beneficiary.

5. Direct interventions in de-escalating situations to prevent crisis.

6. Assisting the beneficiary and natural supports in implementation of therapeutic interventions outlined in the Individual Service Plan.

7. Relapse prevention and disease management strategies.

8. Facilitation of the Individual Service Plan or Recovery Support Plan which includes the active involvement of the beneficiary and the people identified as important in the beneficiary's life.

F. Crisis Residential Services as medically monitored residential short-term psychiatric stabilization services provided in a setting other than an acute care hospital or a long-term residential treatment facility which consist of no more than sixteen (16) beds.

G. Crisis Response Services as time-limited intensive intervention provided by trained crisis response staff, available twenty-four (24) hours a day, seven (7) days a week and includes the assessment of the crisis and ability to activate a mobile crisis team, crisis stabilization and treatment of a beneficiary to avoid inpatient hospitalization.

H. Family Therapy as face-to-face psychotherapy between a mental health therapist and a beneficiary's family members, with or without the presence of the beneficiary, which may also include others with whom the beneficiary lives or has a family-like relationship. Family Therapy includes family psychotherapy, psychoeducation, and family-to-family training.

I. Group Therapy as face-to-face psychotherapy addressing the needs of several individuals within a group.

J. Individual Therapy as face-to-face, one-on-one psychotherapy that takes place between a mental health therapist and a beneficiary.

K. Intensive Community Outreach and Recovery Team (ICORT) Services as a team-oriented approach to mental health rehabilitation intervention and supports necessary to assist beneficiaries in achieving and maintaining rehabilitative, resiliency and recovery goals with a severe and persistent mental illness.

L. Interactive Complexity in:

1. Group therapy as psychotherapy using non-verbal communication and/or physical aids between a mental health therapist and no more than six (6) individuals under the age of twenty-one (21) at the same time.

2. Individual therapy as the one-on-one psychotherapy using non-verbal communication and/or physical aids between a mental health practitioner and a beneficiary who have not yet developed or have lost their expressive communication ability or do not have the cognitive ability to understand the mental health practitioner if ordinary language is used.

M. Medication Administration as the administering of a prescribed medication.

N. Medication Evaluation as regular and periodic monitoring of the therapeutic and side effects of psychotropic medications prescribed for the treatment of a mental illness.

O. Multifamily Group Therapy as therapy taking place between a licensed and enrolled provider or CMHC/PMHC staff and family members of at least two (2) different beneficiaries in a group setting.

P. Nursing assessment as an assessment of a beneficiary's psychological, physiological and sociological history.

Q. Peer Support Services as person-centered services with a rehabilitation and recovery focus designed to promote skills for coping with and managing psychiatric symptoms while facilitating the utilization of natural resources and the enhancement of community living skills.

R. Program of Assertive Community Treatment (PACT) as therapeutic programs provided in the community in which beneficiaries live that would traditionally need inpatient care and treatment but can be maintained in a less restrictive/community-based setting.

S. Psychiatric Diagnostic Evaluation as an integrated biopsychosocial assessment, including history, mental status, and recommendations.

T. Psychological Evaluation as the assessment of a beneficiary's cognitive, emotional, behavioral, and social functioning by a licensed psychologist using standardized tests, interviews, and behavioral observations.

U. Psychosocial Rehabilitation as an active treatment program designed to support and restore community functioning and well-being of an adult beneficiary who has been diagnosed with a serious and persistent mental illness by providing systematic, curriculum based interventions for skills development and to promote recovery in the beneficiary's community by alleviating psychiatric decompensation, confusion, anxiety, feelings of low self-worth, isolation and withdrawal.

V. Psychotherapeutic Services as intentional, face-to-face interactions, conversations or non-verbal encounters between a mental health therapist and a beneficiary, an individual, family or group where a therapeutic relationship is established to help resolve symptoms of the beneficiary's mental and/or emotional disturbance.

W. Quasi-governmental CMHCs are defined as entities operated under the supervision of regional commissions appointed by county boards of supervisors comprising their respective catchment areas.

X. Senior Psychosocial Rehabilitation as a program of structured activities designed to support and enhance the ability of senior beneficiaries to function at the highest possible level of independence in the most integrated community setting appropriate to their needs.

Y. Targeted Case Management as services furnished to assist chronically mentally ill beneficiaries who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services

Z. Treatment Plan as the plan that directs the treatment of the beneficiary and may be referred to as the plan of care, individualized service plan, wraparound plan or person-centered plan depending on the services provided.

AA. Treatment Plan Development and Review as the development and review of an overall treatment plan that directs the treatment and support of the person receiving services by qualified mental health providers.

Source: 42 C.F.R. §§ 440.130, 440.169; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised and renumbered to correspond with MS SPA 20-0022 (eff. 09/01/20) eff. 11/01/2020.

Rule 1.3: Covered Services

A. The Division of Medicaid covers four (4) medically necessary mental health assessments by a non-physician per fiscal year when:

1. Completed during the intake process and/or when there is a need for reassessment.

2. Provided by a staff member who holds a master's degree and professional license or is one (1) of the following as appropriate:

a) A Department of Mental Health (DMH) Certified Mental Health Therapist (CMHT),

b) DMH Certified Intellectual and Developmental Disabilities Therapist (CIDDT), or

c) A DMH Certified Addiction Therapist (CAT).

B. The Division of Medicaid covers up to twelve (12) brief emotional/behavioral health assessments when administered via a standardized behavioral or emotional assessment tool when medically necessary to identify emotional and/or behavioral conditions, including, but not limited to:

1. Depression,

2. Alcohol, substance use or substance abuse,

3. Attention Deficit Hyperactivity Disorder (ADHD), or

4. Other behavioral disorders that may require treatment and/or other forms of intervention.

C. The Division of Medicaid covers four (4) medically necessary treatment plan development and reviews per state fiscal year when:

1. Part of a treatment plan approved by one (1) of the providers listed in Miss. Admin. Code Title 23, Part 206, Rule 1.1.B.1 through B.8., and

2. Provided by one of the providers listed in Miss. Admin. Code Title 23, Part 206, Rule 1.1 B.1 through B.8 or B.9.c.

D. The Division of Medicaid covers medically necessary Targeted Case Management which must include:

1. Completion of a comprehensive assessment and periodic reassessments of beneficiary needs to determine the need for services, including:

a) Beneficiary history,

b) Identifying the needs of the beneficiary and completing related documentation, and

c) Gathering information from other sources to form a complete assessment/reassessment of the beneficiary.

2. Development and periodic revisions of a specific treatment plan that is based on the information collected through the assessment/reassessments that:

a) Specifies the goals and actions to address the medical, social, educational, and other services needed by the beneficiary,

b) Includes activities such as ensuring the active participation of the eligible beneficiary, and working with the beneficiary or the beneficiary's authorized health care decision maker and others to develop those goals,

c) Identifies a course of action to respond to the assessed needs of the eligible beneficiary,

d) Provides referral and related activities, such as scheduling appointments for the beneficiary, to address any identified needs including medical, social, educational providers, or other programs and services to address identified needs and achieve goals specified in the treatment plan.

3. Monitoring and follow-up activities including:

a) Activities and contacts necessary to ensure the treatment plan is implemented and adequately addresses the beneficiary's needs, which may include with the family members, service providers, or other entities or individuals conducted as frequently as necessary including at least one (1) annual monitoring, to determine whether the following conditions are met:

b) Services are being furnished in accordance with the beneficiary's treatment plan;

c) Services in the treatment plan are adequate; and

d) Changes in the needs or status of the beneficiaries are reflected in the treatment plan. Monitoring and follow-up activities at least annually include making necessary adjustments in the treatment plan and service arrangements with providers.

E. The Division of Medicaid covers medically necessary crisis response services that meet the DMH standards of operation.

1. Crisis response services include:

a) Assessment,

b) De-escalation, and

c) Service coordination and facilitation.

2. Crisis response teams must include:

a) A Certified Peer Support Professional with specific roles and responsibilities,

b) A licensed and/or Credentialed Master's Level Therapist with experience and training in crisis response,

c) A Community Support Specialist with experience and training in crisis response,

d) A Crisis Response Coordinator for the provider's catchment area who is a licensed and/or credentialed master's level therapist with a minimum of two (2) years' experience and training in crisis response, and

e) At least one (1) employee with experience and training in crisis response to each population served by the provider.

F. The Division of Medicaid covers up to sixty (60) days of medically necessary crisis residential services per state fiscal year when ordered by a psychiatrist, physician, psychologist, psychiatric mental health nurse practitioner (PMHNP) or physician assistant (PA) and prior authorized by the Division of Medicaid, Utilization Management/Quality Improvement Organization (UM/QIO) or designee.

1. Crisis residential services must provide the following within twenty-four (24) hours of admission:

a) Initial assessment,

b) Medical screening,

c) Drug toxicology screening, and

d) Psychiatric consultation.

2. Crisis residential services include:

a) Treatment plan development and review,

b) Medication management,

c) Nursing assessment,

d) Individual therapy,

e) Family therapy,

f) Group therapy, and

g) Skill building groups such as social skills training, self-esteem building, anger control, conflict resolution and daily living skills.

3. Crisis residential room and board is not covered by the Division of Medicaid.

4. Crisis residential providers must maintain staffing ratios according to DMH standards.

G. The Division of Medicaid covers up to four hundred (400) fifteen (15) minute units per state fiscal year of medically necessary community support services.

1. Community support services must include:

a) Resource coordination that directly increases the acquisition of skills needed to accomplish the goals set forth in the treatment plan.

b) Monitoring and evaluating the effectiveness of interventions, as documented by symptom reduction and progress toward goals.

c) Psychoeducation:

(1) On the identification and self-management of prescribed medication regimen and communication with the prescribing provider.

(2) And training of family, unpaid caregivers, and/or others who have a legitimate role in addressing the needs of the beneficiary.

d) Direct interventions in de-escalating situations to prevent crisis.

e) Home and community visits for the purpose of monitoring the beneficiary's condition and orientation.

f) Assisting the beneficiary and natural supports in implementation of therapeutic interventions outlined in the treatment plan.

2. Community support services must be provided by a Certified Community Support Specialist professional.

H. The Division of Medicaid covers up to four (4) units of medically necessary psychiatric diagnostic evaluations per state fiscal year when prior authorized by the Division of Medicaid, UM/QIO or designee.

I. The Division of Medicaid covers up to four (4) hours of medically necessary psychological diagnostic evaluations per state fiscal year when prior authorized by the Division of Medicaid, UM/QIO or designee and entirely completed by a psychologist.

J. The Division of Medicaid covers medically necessary medication evaluation and management services.

1. Medication evaluation and management services provided by community/private mental health centers are not limited.

2. Medication evaluation and management services provided by independent practitioners within their scope of practice are subject to the physician visit limits in Miss. Admin. Code Title 23, Part 203, Rule 9.5.C.1.

3. Medication evaluation and management must be provided by one (1) of the following:

a) Psychiatrist,

b) Physician,

c) PMHNP, or

d) PA.

K. The Division of Medicaid covers medically necessary medication administration per state fiscal year when provide by one (1) of the following:

1. Psychiatrist,

2. Physician,

3. PMHNP,

4. PA,

5. RN, or

6. LPN.

L. The Division of Medicaid covers up to one hundred forty-four (144), fifteen (15) minute units of nursing assessments performed by an RN per state fiscal year.

M. The Division of Medicaid covers the following medically necessary psychotherapeutic services when part of a treatment plan approved by one (1) of the providers listed in Miss. Admin. Code Part 206, Rule 1.1.B.1 through B.8. and provided by one of the providers listed in Miss. Admin. Code Part 206, Rule 1.1.B.1 through B.8. or B.9.c) as appropriate:

1. Up to thirty-six (36) individual therapy sessions per state fiscal year,

2. Up to twenty-four (24) family therapy sessions per state fiscal year,

3. A combined total of up to forty (40) group therapy or multi-family group therapy sessions per state fiscal year, and

4. Interactive complexity for individual and group therapy as appropriate within yearly limits.

N. The Division of Medicaid covers up to one hundred (100) days of medically necessary acute partial hospitalization services when prior authorized by the Division of Medicaid, UM/QIO or designee.

1. Acute partial hospitalization includes, but is not limited to:

   a) Treatment plan development and review,

   b) Medication management,

   c) Nursing assessment,

   d) Individual therapy,

   e) Group therapy, and

   f) Family therapy.

2. Acute partial hospitalization programs must be provided by licensed/certified providers including, but not limited to:

   a) CMHC/PMHC,

   b) The outpatient department of a hospital or free-standing psychiatric unit, or

   c) A private psychiatric clinic.

O. The Division of Medicaid covers up to five (5) hours per day, five (5) days per week of medically necessary psychosocial rehabilitation when prior authorized by the Division of Medicaid, UM/QIO or designee.

1. Psychosocial rehabilitation services are not covered when provided on the same day as group therapy, senior psychosocial rehabilitation, crisis residential services or acute partial hospitalization.

2. Psychosocial rehabilitation services must be included in a treatment plan approved by one (1) of the providers listed in Miss. Admin. Code Title 23, Rule 1.1.B.1 through B.8.

3. Senior psychosocial rehabilitation service must be provided according to DMH standards for that population.

P. The Division of Medicaid covers one thousand six hundred (1600) fifteen minute units per state fiscal year of medically necessary assertive community treatment services provided through Programs of Assertive Community Treatment (PACT).

1. PACT is an all-inclusive service that includes, but is not limited to:

a) Treatment plan review and development,

b) Medication management,

c) Individual therapy,

d) Family therapy,

e) Group therapy,

f) Community support, and

g) Peer support.

2. The composition of the PACT team members must include, but is not limited to:

a) A team leader,

b) A Psychiatrist or PMHNP,

c) RN,

d) Master's level mental health professional,

e) Substance use disorder specialist,

f) Employment specialist,

g) Certified peer support specialist professional, and

h) Other clinical personnel as determined by DMH.

Q. The Division of Medicaid covers up to two hundred and seventy (270) days per year of medically necessary intensive community outreach and recovery team (ICORT) services when prior authorized by the Division of Medicaid, UM/QIO or designee.

1. ICORT services include:

a) Treatment plan development and review,

b) Medication management,

c) Individual therapy and family therapy in the home,

d) Group therapy,

e) Peer support services,

f) Community support services,

g) Skill building groups, including but not limited to:

1) Social skills training,

2) Self-esteem building,

3) Anger control,

4) Conflict resolution, and

5) Daily living skills.

2. ICORT providers must have the following staff:

a) Team Leader which must be a full-time Master's Level Mental Health Therapist,

b) A full-time registered nurse,

c) A full-time equivalent Certified Peer Support Specialist Professional,

d) A part-time clerical personnel, and

e) If deemed necessary by the DMH, a part-time Community Support Specialist must be added to ICORT.

3. ICORT services must be included in a treatment plan approved by one (1) of the providers listed in Miss. Admin. Code. Title 23, Part 106, Rule 1.1.B.1. through B.8.

4. Development and revision of a specific treatment plan based on the information collected through the assessment which must include:

    a) Goals and actions to address the medical, social, educational, and other services needed by the beneficiary,

    b) Activities such as ensuring the active participation of the beneficiary and working with the beneficiary or beneficiary's representative and others to develop goals, and

    c) A course of action to respond to the assessed needs of the beneficiary.

5. Referral and related activities to help the beneficiary obtain needed services, including but not limited to:

    a) Scheduling appointments, and

    b) Linking the beneficiary with medical, social and educational providers or other programs and services that provide needed services as identified in the treatment plan.

6. Monitoring and follow-up activities to ensure the treatment plan is effectively implemented and adequately addresses the needs of the beneficiary conducted annually and as necessary to ensure:

    a) Services are being furnished in accordance with the beneficiary's treatment plan,

    b) Services in the treatment plan are adequate, and

    c) Any necessary changes to the treatment plan are made based on any changes in the needs or status of the beneficiary.

R. The Division of Medicaid covers up to two hundred (200) fifteen (15) minute units per state fiscal year of medically necessary peer support services.

1. Peer support services must include:

    a) Development of a recovery support plan, and

    b) Skill building for coping with and managing symptoms while utilizing natural resources, and the preservation and enhancement of community living skills.

2. Services must be provided by a certified Peer Support Specialist Professional.

Source: 42 C.F.R. §§ 440.130, 440.169; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised and renumbered to correspond with MS SPA 20-0022 (eff. 09/01/20) eff. 11/01/2020.

Rule 1.4: Non-Covered Services

A. The Division of Medicaid does not cover community mental health services that:

1. Have not been certified by the Department of Mental Health (DMH),

2. Do not meet the standards specified by DMH,

3. Are not medically necessary,

4. Are not prior authorized by the Division of Medicaid, Utilization Management/Quality Improvement Organization (UM/QIO) or designee, if required, and

5. Are not part of a plan of care or treatment plan approved by a team member qualified to approve the service being provided.

B. The Division of Medicaid does not cover the following activities and/or services:

1. Time spent completing paperwork,

2. Telephone contacts, unless included in the service definition,

3. Recreational activities,

4. Educational interventions,

5. Travel time,

6. Missed or canceled appointments,

7. Room and board, and/or

8 Services provided to a beneficiary during an inpatient stay, unless included in the service definition.

C. The Division of Medicaid does not cover services and/or programs that do not meet the standards of the licensing/certifying agency when applicable.

Source: 42 C.F.R. §§ 440.130, 440.169; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised and renumbered to correspond with MS SPA 20-0022 (eff. 09/01/20) eff. 11/01/2020.

Rule 1.5: Reimbursement

A. The Division of Medicaid reimburses for covered community mental health services according to a statewide uniform fee schedule.

B. Reimbursement for physician services provided outside of a Community or Private Mental health center are subject to the limits described in Miss. Admin. Code Title 23, Part 203.

C. Intensive Community Outreach and Recovery Team (ICORT) providers must provide at least thirty (30) minutes of service in one (1) day in order for the Division of Medicaid to reimburse the per diem rate.

Source: 42 C.F.R. §§ 440.130; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised and renumbered to correspond with MS SPA 20-0022 (eff. 09/01/20) eff. 11/01/2020.

Rule 1.6: Documentation

A. All services must be documented on a treatment plan and approved, signed and dated by a licensed practitioner operating within their scope of practice.

B. The following must be documented in the beneficiary's case record for each service provided:

1. Type of service provided,

2. Date of service,

3. Length of time spent providing the service,

4. Start and end times of sessions,

5. Names of all individuals receiving or participating in the service,

6. Summary of session,

7. Explanation of how the service relates to the goals and objectives established in the treatment plan,

8. Name and title of servicing provider, and

9. Signature and credentials of servicing provider/practitioner.

C. Community mental health services must be documented according to the Department of Mental Health (DMH) Record Guide and any supplemental instructions provided by DMH in effect at the time the service is provided.

Source: 42 C.F.R. §§ 440.130, 440.169; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised and renumbered to correspond with MS SPA 20-0022 (eff. 09/01/20) eff. 11/01/2020

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Rule 1.1: Provider Requirements

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1. Provide proof of certification by the Mississippi Department of Mental Health (MDMH), professional license, or certification and/or license from the appropriate agency as required by the Division of Medicaid,

2. Provide proof that the services they provide have been certified by the appropriate agency when applicable,

3. Meet the applicable requirements described in Miss. Admin Code Part 200, Chapter 4,

4. Provide a National Provider Identifier (NPI), verification from the National Plan and Provider Enumeration System (NPPES), and

5. Submit written confirmation from the Internal Revenue Service (IRS) of the Provider's tax identification number and legal business name.

B. Rehabilitative services must be provided by the following licensed and enrolled providers acting within their scope of practice:

1. Board-certified or board-eligible psychiatrists licensed by the Mississippi Board of Medical Licensure.

2. Physicians licensed by the Mississippi Board of Medical Licensure acting within their scope of practice.

3. Physician Assistants (PA) must hold a Master’s degree in a health related or science field, be licensed by the Mississippi Board of Medical Licensure, and must be under the supervision of a psychiatrist or a physician.

4. Psychiatric Mental Health Nurse Practitioners (PMHNP) must hold a Master’s degree in nursing with a specialty in psychiatry, be licensed by the Mississippi Board of Nursing, and must practice within a collaborative/consultative relationship with a physician within an established protocol or practice guidelines.

5. Psychologists must hold a Ph.D. degree in psychology and be licensed by the Mississippi Board of Psychology.

6. Licensed Certified Social Workers (LCSW) must hold a Master's degree in social work and be licensed by the Mississippi State Board of Examiners for Social Workers and Marriage and Family Therapists at the LCSW level.

7. Licensed Professional Counselors (LPC) must hold a Master's degree in counseling and be licensed by the Mississippi State Board of Examiners for Licensed Professional Counselors. Provisionally Licensed Professional Counselors (P-LPCs) may provide services within the scope of their provisional license.

8. Quasi-governmental Community Mental Health Center (CMHC) agencies and private mental health centers (PMHCs) certified according to Mississippi Code Ann. § 41-4-7 by the Mississippi Department of Mental Health (DMH).

    a. DMH issues a four (4) year certification for CMHCs/PMHCs and the services provided unless stated otherwise at the time of certification.

    b. DMH certification is based on the following:

        1) Adherence to DMH standards, DMH grant requirement guidelines, contracts, memoranda of understanding, and memoranda of agreement;

        2) Compliance with DMH fiscal management standards and practices outlined in the DMH Operational Standards based on a risk-based audit system;

        3) Evidence of fiscal compliance with external funding sources;

        4) Compliance with ethical practices and codes of conduct of professional licensing entities related to provision of services and management of the organization; and

        5) Evidence of solid business and management practices.

    c. Staff qualifications for CMHC/PMHC:

        1) Qualifications for providers listed in Miss. Admin. Code Part 206, Rule 1.1.B.1. through B.8 above are applicable in CMHC/PMHC,

        2) Professional Art Therapists (ATR-BC) must hold a Master's degree in art therapy and be licensed by the Mississippi Department of Health.

        3) Registered Nurses (RN) must be a graduate from an approved or accredited RN nursing program, be licensed by the Mississippi Board of Nursing, and must be under the supervision of a psychiatrist, physician, PMHNP, or PA.

        4) Licensed Practical Nurses (LPN) must be a graduate from an approved or accredited LPN nursing program, be licensed by the Mississippi Board of Nursing and supervised by a psychiatrist, physician, PMHNP, PA or RN.

5) Licensed Marriage and Family Therapists (LMFT) must hold a Master's degree in marriage and family therapy and be licensed by the Mississippi State Board of Examiners for Social Workers and Marriage and Family Therapists.

6) DMH certifies the following staff:

(a) Certified Mental Health Therapists (CMHT), Certified Intellectual and Developmental Disabilities Therapists (CIDDT) and Certified Addiction Therapists (CAT) must hold a Master's degree in mental health, human services, intellectual disabilities, addictions, or behavioral health related fields from an approved educational institution.

(1) Provisionally certified therapists are temporarily certified while fulfilling all the certification requirements, provide the same services as a CMHT, CIDDT and CAT and must be under the supervision of certified therapist of the same discipline. Provisional certification is valid for up to twenty-four (24) consecutive months from the date of issuance.

(2) The certified credential is full certification and renewable every four (4) years as long as renewal requirements are met.

(b) Community Support Specialists must hold a minimum of a Bachelor's degree in a mental health field, be certified by DMH as a Community Support Specialist and must be under the supervision of staff listed Miss. Admin. Code Part 206, Rule in 1.1.B.1. and B.8.

(c) Peer Support Specialist Professionals must hold a minimum of a high school diploma or GED equivalent, , be certified by DMH as a Certified Peer Support Specialist and must be under the supervision of a psychiatrist, physician, PMHNP, PA, LCSW, LPC, LMFT, CMHT, CIDDT, CAT or a Peer Support Specialist Supervisor who has been trained as a Peer Support Specialist with an emphasis on supervision.

(d) Peer Support Specialist supervisors must hold a minimum of a master's degree in addictions, mental health, intellectual/developmental disabilities, or human or behavioral services field and either a 1) professional license or 2) a DMH credential as a Mental Health Therapist, Intellectual/Developmental Disability Therapist, or Addictions therapist prior to or immediately upon acceptance of a Peer Support Specialist Supervisory position and must also receive training specifically developed for Peer Support Specialist supervisors by DMH.

(e) Certified Wraparound Facilitators must hold a minimum of a bachelor's degree in a mental health, intellectual/developmental disabilities, or human services/behavioral health-related field and a DMH Community Support Specialist credential and complete the "Introduction to Wraparound" 3-day

training, be certified by DMH, and must be under the supervision of a psychiatrist, physician, PMHNP, PA, LCSW, LPC, LMFT, CMHT, CIDDT, or a CAT who has completed the "Introduction to Wraparound" 3-day training and hold a DMH High Fidelity Wraparound certificate.

7) Staff members who are provisionally certified must be supervised by a licensed professional or a credentialed DMH Certified Mental Health Therapist, DMH Certified Intellectual and Development Disabilities Therapist or DMH Certified Addiction Therapist of the same discipline.

C. Evidence–based practices (EBP) or evidence-informed best practices must be provided by a master's degree therapist who holds a professional license or DMH certification and has completed appropriate training in that evidence-based practice.

Source: 42 C.F.R. §§ 440.130, 440.169; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised and renumbered to correspond with MS SPA 20-0022 (eff. 09/01/20) eff. 11/01/2020.

Rule 1.2: Definitions

The Division of Medicaid defines:

A. Assessment as obtaining from the beneficiary, beneficiary's family or others involved in the beneficiary's care, the beneficiary's family background/ educational/vocational achievement, presenting problem(s), problem history, history of previous treatment, medical history, current medication(s), source of referral and other pertinent information in order to determine the nature of the beneficiary's or family's problem(s), the factors contributing to the problem(s), and the most appropriate course of treatment for the beneficiary.

B. Acute Partial Hospitalization as a program that provides medical supervision, nursing services, structured therapeutic activities and intensive psychotherapy (individual, family and/or group) to beneficiaries who are experiencing a period of such acute distress that their ability to cope with normal life circumstances is severely impaired. Acute Partial Hospitalization is designed to provide an alternative to inpatient hospitalization for such beneficiaries or to serve as a bridge from inpatient hospital to outpatient hospital or community treatment. Program content may vary based on beneficiary need but must include close observation/supervision and intensive support with a focus on the reduction/elimination of acute symptoms.

C. A Brief Emotional/Behavioral Health Assessment as a brief screening used to assess a beneficiary's emotional and/or behavioral health and covers a variety of standardized assessments aimed to identify the need for more in-depth evaluation for a number of mental/behavioral conditions.

D. Clinical Staff member as a staff member who holds, at a minimum, a master's degree and professional license or who is a DMH Certified Mental Health Therapist (CMHT), DMH

Certified Intellectual and Developmental Disabilities Therapist (CIDDT) or a DMH Certified Addiction Therapist (CAT) when appropriate.

E. Community Support Services as services that are specific, measurable, and individualized that focus on the beneficiary's ability to succeed in the community, to identify and access needed services, and to show improvement in school, work, and family and integration and contributions within the community and include the following as clinically indicated:

1. Identification of strengths which aid the beneficiary in their recovery and the barriers that will challenge the development of skills necessary for independent functioning in the community.

2. Individual therapeutic interventions that directly increase the acquisition of skills needed to accomplish the goals set forth in the Individual Service Plan.

3. Monitoring and evaluating the effectiveness of interventions as evidenced by symptom reduction and program toward goals.

4. Psychoeducation which includes:

   a) Identification and self-management of the prescribed medication regimen and communication with the prescribing provider.

   b) Training of family, unpaid caregivers, and/or others who have a legitimate role in addressing the needs of the beneficiary.

5. Direct interventions in de-escalating situations to prevent crisis.

6. Assisting the beneficiary and natural supports in implementation of therapeutic interventions outlined in the Individual Service Plan.

7. Relapse prevention and disease management strategies.

8. Facilitation of the Individual Service Plan or Recovery Support Plan which includes the active involvement of the beneficiary and the people identified as important in the beneficiary's life.

F. Crisis Residential Services as medically monitored residential short-term psychiatric stabilization services provided in a setting other than an acute care hospital or a long-term residential treatment facility which consist of no more than sixteen (16) beds.

G. Crisis Response Services as time-limited intensive intervention provided by trained crisis response staff, available twenty-four (24) hours a day, seven (7) days a week and includes the assessment of the crisis and ability to activate a mobile crisis team, crisis stabilization and treatment of a beneficiary to avoid inpatient hospitalization.

H. Family Therapy as face-to-face psychotherapy between a mental health therapist and a beneficiary's family members, with or without the presence of the beneficiary, which may also include others with whom the beneficiary lives or has a family-like relationship. Family Therapy includes family psychotherapy, psychoeducation, and family-to-family training.

I. Group Therapy as face-to-face psychotherapy addressing the needs of several individuals within a group.

J. Individual Therapy as face-to-face, one-on-one psychotherapy that takes place between a mental health therapist and a beneficiary.

K. Intensive Community Outreach and Recovery Team (ICORT) Services as a team-oriented approach to mental health rehabilitation intervention and supports necessary to assist beneficiaries in achieving and maintaining rehabilitative, resiliency and recovery goals with a severe and persistent mental illness.

L. Interactive Complexity in:

2. Group therapy as psychotherapy using non-verbal communication and/or physical aids between a mental health therapist and no more than six (6) individuals under the age of twenty-one (21) at the same time.

2. Individual therapy as the one-on-one psychotherapy using non-verbal communication and/or physical aids between a mental health practitioner and a beneficiary who have not yet developed or have lost their expressive communication ability or do not have the cognitive ability to understand the mental health practitioner if ordinary language is used.

M. Medication Administration as the administering of a prescribed medication.

N. Medication Evaluation as regular and periodic monitoring of the therapeutic and side effects of psychotropic medications prescribed for the treatment of a mental illness.

O. Multifamily Group Therapy as therapy taking place between a licensed and enrolled provider or CMHC/PMHC staff and family members of at least two (2) different beneficiaries in a group setting.

P. Nursing assessment as an assessment of a beneficiary's psychological, physiological and sociological history.

Q. Peer Support Services as person-centered services with a rehabilitation and recovery focus designed to promote skills for coping with and managing psychiatric symptoms while facilitating the utilization of natural resources and the enhancement of community living skills.

R. Program of Assertive Community Treatment (PACT) as therapeutic programs provided in the community in which beneficiaries live that would traditionally need inpatient care and treatment but can be maintained in a less restrictive/community-based setting.

S. Psychiatric Diagnostic Evaluation as an integrated biopsychosocial assessment, including history, mental status, and recommendations.

T. Psychological Evaluation as the assessment of a beneficiary's cognitive, emotional, behavioral, and social functioning by a licensed psychologist using standardized tests, interviews, and behavioral observations.

U. Psychosocial Rehabilitation as an active treatment program designed to support and restore community functioning and well-being of an adult beneficiary who has been diagnosed with a serious and persistent mental illness by providing systematic, curriculum based interventions for skills development and to promote recovery in the beneficiary's community by alleviating psychiatric decompensation, confusion, anxiety, feelings of low self-worth, isolation and withdrawal.

V. Psychotherapeutic Services as intentional, face-to-face interactions, conversations or non-verbal encounters between a mental health therapist and a beneficiary, an individual, family or group where a therapeutic relationship is established to help resolve symptoms of the beneficiary's mental and/or emotional disturbance.

W. Quasi-governmental CMHCs are defined as entities operated under the supervision of regional commissions appointed by county boards of supervisors comprising their respective catchment areas.

X. Senior Psychosocial Rehabilitation as a program of structured activities designed to support and enhance the ability of senior beneficiaries to function at the highest possible level of independence in the most integrated community setting appropriate to their needs.

Y. Targeted Case Management as services furnished to assist chronically mentally ill beneficiaries who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services

Z. Treatment Plan as the plan that directs the treatment of the beneficiary and may be referred to as the plan of care, individualized service plan, wraparound plan or person-centered plan depending on the services provided.

AA. Treatment Plan Development and Review as the development and review of an overall treatment plan that directs the treatment and support of the person receiving services by qualified mental health providers.

Source: 42 C.F.R. §§ 440.130, 440.169; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised and renumbered to correspond with MS SPA 20-0022 (eff. 09/01/20) eff. 11/01/2020.

Rule 1.3: Covered Services

A. The Division of Medicaid covers four (4) medically necessary mental health assessments by a non-physician per fiscal year when:

1. Completed during the intake process and/or when there is a need for reassessment.

2. Provided by a staff member who holds a master's degree and professional license or is one (1) of the following as appropriate:

a) A Department of Mental Health (DMH) Certified Mental Health Therapist (CMHT),

b) DMH Certified Intellectual and Developmental Disabilities Therapist (CIDDT), or

c) A DMH Certified Addiction Therapist (CAT).

B. The Division of Medicaid covers up to twelve (12) brief emotional/behavioral health assessments when administered via a standardized behavioral or emotional assessment tool when medically necessary to identify emotional and/or behavioral conditions, including, but not limited to:

1. Depression,

2. Alcohol, substance use or substance abuse,

3. Attention Deficit Hyperactivity Disorder (ADHD), or

4. Other behavioral disorders that may require treatment and/or other forms of intervention.

C. The Division of Medicaid covers four (4) medically necessary treatment plan development and reviews per state fiscal year when:

1. Part of a treatment plan approved by one (1) of the providers listed in Miss. Admin. Code Title 23, Part 206, Rule 1.1.B.1 through B.8., and

2. Provided by one of the providers listed in Miss. Admin. Code Title 23, Part 206, Rule 1.1 B.1 through B.8 or B.9.c.

D. The Division of Medicaid covers medically necessary Targeted Case Management which must include:

1. Completion of a comprehensive assessment and periodic reassessments of beneficiary needs to determine the need for services, including:

a) Beneficiary history,

b) Identifying the needs of the beneficiary and completing related documentation, and

c) Gathering information from other sources to form a complete assessment/reassessment of the beneficiary.

2. Development and periodic revisions of a specific treatment plan that is based on the information collected through the assessment/reassessments that:

a) Specifies the goals and actions to address the medical, social, educational, and other services needed by the beneficiary,

b) Includes activities such as ensuring the active participation of the eligible beneficiary, and working with the beneficiary or the beneficiary's authorized health care decision maker and others to develop those goals,

c) Identifies a course of action to respond to the assessed needs of the eligible beneficiary,

d) Provides referral and related activities, such as scheduling appointments for the beneficiary, to address any identified needs including medical, social, educational providers, or other programs and services to address identified needs and achieve goals specified in the treatment plan.

3. Monitoring and follow-up activities including:

a) Activities and contacts necessary to ensure the treatment plan is implemented and adequately addresses the beneficiary's needs, which may include with the family members, service providers, or other entities or individuals conducted as frequently as necessary including at least one (1) annual monitoring, to determine whether the following conditions are met:

b) Services are being furnished in accordance with the beneficiary's treatment plan;

c) Services in the treatment plan are adequate; and

d) Changes in the needs or status of the beneficiaries are reflected in the treatment plan. Monitoring and follow-up activities at least annually include making necessary adjustments in the treatment plan and service arrangements with providers.

E. The Division of Medicaid covers medically necessary crisis response services <u>that meet the DMH standards of operation</u>.

1. Crisis response services include:

a) Assessment,

b) De-escalation, and

c) Service coordination and facilitation.

2. Crisis response teams must include:

a) A Certified Peer Support Professional with specific roles and responsibilities,

b) A licensed and/or Credentialed Master's Level Therapist with experience and training in crisis response,

c) A Community Support Specialist with experience and training in crisis response,

d) A Crisis Response Coordinator for the provider's catchment area who is a licensed and/or credentialed master's level therapist with a minimum of two (2) years' experience and training in crisis response, and

e) At least one (1) employee with experience and training in crisis response to each population served by the provider.

F. The Division of Medicaid covers up to sixty (60) days of medically necessary crisis residential services per state fiscal year when ordered by a psychiatrist, physician, psychologist, psychiatric mental health nurse practitioner (PMHNP) or physician assistant (PA) and prior authorized by the Division of Medicaid, Utilization Management/Quality Improvement Organization (UM/QIO) or designee.

1. Crisis residential services must provide the following within twenty-four (24) hours of admission:

a) Initial assessment,

b) Medical screening,

c) Drug toxicology screening, and

d) Psychiatric consultation.

2. Crisis residential services include:

a) Treatment plan development and review,

b) Medication management,

c) Nursing assessment,

d) Individual therapy,

e) Family therapy,

f) Group therapy,

~~g) Crisis response,~~ and

~~g~~h) Skill building groups such as social skills training, self-esteem building, anger control, conflict resolution and daily living skills.

3. Crisis residential room and board is not covered by the Division of Medicaid.

4. Crisis residential providers must maintain staffing ratios according to DMH standards.

G. The Division of Medicaid covers up to four hundred (400) fifteen (15) minute units per state fiscal year of medically necessary community support services.

1. Community support services must include:

a) Resource coordination that directly increases the acquisition of skills needed to accomplish the goals set forth in the treatment plan.

b) Monitoring and evaluating the effectiveness of interventions, as documented by symptom reduction and progress toward goals.

c) Psychoeducation:

(3) On the identification and self-management of prescribed medication regimen and communication with the prescribing provider.

(4) And training of family, unpaid caregivers, and/or others who have a legitimate role in addressing the needs of the beneficiary.

d) Direct interventions in de-escalating situations to prevent crisis.

e) Home and community visits for the purpose of monitoring the beneficiary's condition and orientation.

f) Assisting the beneficiary and natural supports in implementation of therapeutic interventions outlined in the treatment plan.

2. Community support services must be provided by a Certified Community Support Specialist professional.

H. The Division of Medicaid covers up to four (4) units of medically necessary psychiatric diagnostic evaluations per state fiscal year when prior authorized by the Division of Medicaid, UM/QIO or designee.

I. The Division of Medicaid covers up to four (4) hours of medically necessary psychological diagnostic evaluations per state fiscal year when prior authorized by the Division of Medicaid, UM/QIO or designee and entirely completed by a psychologist.

J. The Division of Medicaid covers medically necessary medication evaluation and management services.

1. Medication evaluation and management services provided by community/private mental health centers are not limited.

2. Medication evaluation and management services provided by independent practitioners within their scope of practice are subject to the physician visit limits in Miss. Admin. Code Title 23, Part 203, Rule 9.5.C.1.

3. Medication evaluation and management must be provided by one (1) of the following:

a) Psychiatrist,

b) Physician,

c) PMHNP, or

d) PA.

K. The Division of Medicaid covers medically necessary medication administration per state fiscal year when provide by one (1) of the following:

1. Psychiatrist,

2. Physician,

3. PMHNP,

4. PA,

5. RN, or

6. LPN.

L. The Division of Medicaid covers up to one hundred forty-four (144), fifteen (15) minute units of nursing assessments performed by an RN per state fiscal year.

M. The Division of Medicaid covers the following medically necessary psychotherapeutic services when part of a treatment plan approved by one (1) of the providers listed in Miss. Admin. Code Part 206, Rule 1.1.B.1 through B.8. and provided by one of the providers listed in Miss. Admin. Code Part 206, Rule 1.1.B.1 through B.8. or B.9.c) as appropriate:

1. Up to thirty-six (36) individual therapy sessions per state fiscal year,

2. Up to twenty-four (24) family therapy sessions per state fiscal year,

3. A combined total of up to forty (40) group therapy or multi-family group therapy sessions per state fiscal year, and

4. Interactive complexity for individual and group therapy as appropriate within yearly limits.

N. The Division of Medicaid covers up to one hundred (100) days of medically necessary acute partial hospitalization services when prior authorized by the Division of Medicaid, UM/QIO or designee.

1. Acute partial hospitalization includes, but is not limited to:

   a) Treatment plan development and review,

   b) Medication management,

   c) Nursing assessment,

   d) Individual therapy,

   e) Group therapy, and

   f) Family therapy.

2. Acute partial hospitalization programs must be provided by licensed/certified providers including, but not limited to:

   a) CMHC/PMHC,

   b) The outpatient department of a hospital or free-standing psychiatric unit, or

   c) A private psychiatric clinic~~, or~~

   ~~d) Other provider approved by the Mississippi Department of Mental Health.~~

O. The Division of Medicaid covers up to five (5) hours per day, five (5) days per week of medically necessary psychosocial rehabilitation when prior authorized by the Division of Medicaid, UM/QIO or designee.

1. Psychosocial rehabilitation services are not covered when provided on the same day as group therapy, senior psychosocial rehabilitation, crisis residential services or acute partial hospitalization.

2. Psychosocial rehabilitation services must be included in a treatment plan approved by one (1) of the providers listed in Miss. Admin. Code Title 23, Rule 1.1.B.1 through B.8.

3. Senior psychosocial rehabilitation service must be provided according to DMH standards for that population.

P. The Division of Medicaid covers one thousand six hundred (1600) fifteen minute units per state fiscal year of medically necessary assertive community treatment services provided through Programs of Assertive Community Treatment (PACT).

1. PACT is an all-inclusive service that includes, but is not limited to:

a) Treatment plan review and development,

b) Medication management,

c) Individual therapy,

d) Family therapy,

e) Group therapy,

f) Community support, and

g) Peer support.

2. The composition of the PACT team members must include, but is not limited to:

a) A team leader,

b) A Psychiatrist or PMHNP,

c) RN,

d) Master's level mental health professional,

e) Substance use disorder specialist,

f) Employment specialist,

g) Certified peer support specialist professional, and

h) Other clinical personnel as determined by DMH.

Q. The Division of Medicaid covers up to two hundred and seventy (270) days per year of medically necessary intensive community outreach and recovery team (ICORT) services when prior authorized by the Division of Medicaid, UM/QIO or designee.

1. ICORT services include:

a) Treatment plan development and review,

b) Medication management,

c) Individual therapy and family therapy in the home,

d) Group therapy,

e) Peer support services,

f) Community support services,

g) Skill building groups, including but not limited to:

1) Social skills training,

2) Self-esteem building,

3) Anger control,

4) Conflict resolution, and

5) Daily living skills.

2. ICORT providers must have the following staff:

a) Team Leader which must be a full-time Master's Level Mental Health Therapist,

b) A full-time registered nurse,

c) A full-time equivalent Certified Peer Support Specialist Professional,

d) A part-time clerical personnel, and

e) If deemed necessary by the DMH, a part-time Community Support Specialist must be added to ICORT.

3. ICORT services must be included in a treatment plan approved by one (1) of the providers listed in Miss. Admin. Code. Title 23, Part 106, Rule 1.1.B.1. through B.8.

4. Development and revision of a specific treatment plan based on the information collected through the assessment which must include:

    a) Goals and actions to address the medical, social, educational, and other services needed by the beneficiary,

    b) Activities such as ensuring the active participation of the beneficiary and working with the beneficiary or beneficiary's representative and others to develop goals, and

    c) A course of action to respond to the assessed needs of the beneficiary.

5. Referral and related activities to help the beneficiary obtain needed services, including but not limited to:

    b) Scheduling appointments, and

    b) Linking the beneficiary with medical, social and educational providers or other programs and services that provide needed services as identified in the treatment plan.

6. Monitoring and follow-up activities to ensure the treatment plan is effectively implemented and adequately addresses the needs of the beneficiary conducted annually and as necessary to ensure:

    a) Services are being furnished in accordance with the beneficiary's treatment plan,

    b) Services in the treatment plan are adequate, and

    c) Any necessary changes to the treatment plan are made based on any changes in the needs or status of the beneficiary.

R. The Division of Medicaid covers up to two hundred (200) fifteen (15) minute units per state fiscal year of medically necessary peer support services.

1. Peer support services must include:

    a) Development of a recovery support plan, and

    b) Skill building for coping with and managing symptoms while utilizing natural resources, and the preservation and enhancement of community living skills.

2. Services must be provided by a certified Peer Support Specialist Professional.

Source: 42 C.F.R. §§ 440.130, 440.169; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised and renumbered to correspond with MS SPA 20-0022 (eff. 09/01/20) eff. 11/01/2020.

Rule 1.4: Non-Covered Services

A. The Division of Medicaid does not cover community mental health services that:

1. Have not been certified by the Department of Mental Health (DMH),

2. Do not meet the standards specified by DMH,

5. Are not medically necessary,

6. Are not prior authorized by the Division of Medicaid, Utilization Management/Quality Improvement Organization (UM/QIO) or designee, if required, and

5. Are not part of a plan of care or treatment plan approved by a team member qualified to approve the service being provided.

B. The Division of Medicaid does not cover the following activities and/or services:

1. Time spent completing paperwork,

2. Telephone contacts, unless included in the service definition,

3. Recreational activities,

4. Educational interventions,

5. Travel time,

6. Missed or canceled appointments,

7. Room and board, and/or

8 Services provided to a beneficiary during an inpatient stay, unless included in the service definition.

C. The Division of Medicaid does not cover services and/or programs that do not meet the standards of the licensing/certifying agency when applicable.

Source: 42 C.F.R. §§ 440.130, 440.169; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised and renumbered to correspond with MS SPA 20-0022 (eff. 09/01/20) eff. 11/01/2020.

Rule 1.5: Reimbursement

A. The Division of Medicaid reimburses for covered community mental health services according to a statewide uniform fee schedule.

B. Reimbursement for physician services provided outside of a Community or Private Mental health center are subject to the limits described in Miss. Admin. Code Title 23, Part 203.

C. Intensive Community Outreach and Recovery Team (ICORT) providers must provide at least thirty (30) minutes of service in one (1) day in order for the Division of Medicaid to reimburse the per diem rate.

Source: 42 C.F.R. §§ 440.130; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised and renumbered to correspond with MS SPA 20-0022 (eff. 09/01/20) eff. 11/01/2020.

Rule 1.6: Documentation

A. All services must be documented on a treatment plan and approved, signed and dated by a licensed practitioner operating within their scope of practice.

B. The following must be documented in the beneficiary's case record for each service provided:

1. Type of service provided,

2. Date of service,

3. Length of time spent providing the service,

4. Start and end times of sessions,

5. Names of all individuals receiving or participating in the service,

6. Summary of session,

7. Explanation of how the service relates to the goals and objectives established in the treatment plan,

8. Name and title of servicing provider, and

9. Signature and credentials of servicing provider/practitioner.

C. Community mental health services must be documented according to the Department of Mental Health (DMH) Record Guide and any supplemental instructions provided by DMH in effect at the time the service is provided.

Source: 42 C.F.R. §§ 440.130, 440.169; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised and renumbered to correspond with MS SPA 20-0022 (eff. 09/01/20) eff. 11/01/2020