Administrative Code

Title 23: Medicaid
Part 206
Mental Health Services

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Rule 1.1 General

A. Purpose

The purpose of these regulations is to set forth the minimum requirements for providers who provide described mental health services to Medicaid beneficiaries in a community mental health setting. These regulations also provide for the maximum number of services that may be provided to a beneficiary daily and annually. Any service that requires prior authorization by the Division of Medicaid is so specified. The regulations have been prepared for the information and guidance of providers of services participating in the Mississippi Medicaid program.

It is the provider's responsibility to assure that the business's employees at all locations are knowledgeable of the Medicaid program requirements and have access to Medicaid regulation, requirements, and other information pertinent to the performance of their duties.

B. Legal Authority

The Division of Medicaid is authorized to promulgate these rules under and by virtue of Section 43-13-121 of the Mississippi Code of 1972, as amended.

As specified in 43-13-117 (16) of the Mississippi Code of 1972, as amended, Community Mental Health Services described in these regulations are approved therapeutic and case management services provided by (a) an approved regional mental health/retardation center established under Sections 41-19-31 through 41-19-39, or by another community mental health service provider meeting the requirements of the Department of Mental Health (DMH) to be an approved mental health/retardation center if determined necessary by DMH, using state funds which are provided from the appropriation to DMH and used to match federal funds under a cooperative agreement between the division and the department, or (b) a facility certified by DMH to provide therapeutic and case management services, to be reimbursed on a fee for service basis. Any such services provided by a facility described in paragraph (b) must have the prior authorization of the Division to be eligible for reimbursement under this section. Any facility described in paragraph (b) must be certified by DMH as a community mental health center and matching funds for services will be funded by DMH.

C. Coverage Criteria

1. The Division of Medicaid will provide coverage for covered mental health services when it is determined that the medically necessary criteria and guidelines listed below are met.

"Medically necessary" or "medical necessity" shall mean health care services that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

a) Appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the patient's medical condition,

b) Compatible with the standards of acceptable medical practice in the United States,

c) Provided in a safe, appropriate and cost-effective community-based setting given the nature of the diagnosis and the severity of the symptoms,

d) Not provided solely for the convenience of the beneficiary or family, or the convenience of any health care provider,

e) Not primarily custodial care,

f) There is no other effective and more conservative or substantially less costly treatment service and setting available,

g) The service is not experimental, investigational or cosmetic in nature, and

h) All Mississippi Medicaid regulations, program rules, exclusions, limitations, and service limits, etc., apply. The fact that a service is medically necessary does not, in itself, qualify the service for reimbursement.

2. Reimbursement is available only for beneficiaries who have Medicaid eligibility for the date the service is provided.

3. Mental Health Services in this Chapter are covered for adult or child beneficiaries of Mississippi Medicaid. Services available to targeted populations only are specified under the appropriate Rule.

D. General Service Requirements

1. Services provided must comply with rules, guidelines and regulations established by the Division of Medicaid.

2. All providers enrolled as community mental health providers must be certified for the provision of the mental health services they provide by the Department of Mental Health on the date of service.

3. Staff providing mental health services must meet minimum qualifications as established by the Division of Medicaid. A staff member must hold at a minimum, a bachelor's degree in a mental health field, in order to provide services billed to Medicaid unless

specifically stated in a rule defining a service. Bachelor's level staff shall not provide therapy services.

4. There must be clear evidence provided in the documentation that services are based on beneficiary need and not convenience of the staff.

5. Beneficiaries shall not be required to participate in services that are not medically necessary or there is no identified need. Beneficiaries shall not be required to participate in one service in order to get another. Determination of needed services must be person-centered.

6. An individual staff member can bill only for the actual time spent in service delivery, not to exceed the amount of total time the staff member actually worked. Staff may not spend the least amount of time possible to equal a billing unit in order to bill nine (9) hours per day when only eight (8) hours were worked.

7. Where there are conflicts between this Administrative Rule, the Division of Medicaid provider manuals and fee schedules or the DMH Standards, the Division of Medicaid Administrative Rule supersedes all else.

8. Interpretations to the Medicaid rules and regulations, including the Mississippi Medicaid Administrative Rule, must be received in writing from the Division of Medicaid. The Division of Medicaid is the only agency that has the authority to render a decision on Medicaid Administrative Rule or other guidance documents.

E. Documentation Requirements

1. All services billed to Medicaid must be included in the treatment plan and must be approved by a licensed independent practitioner in accordance with the appropriate scope of practice. These practitioners are limited to: a Mississippi licensed Physician who holds a specialty in psychiatry, a Mississippi licensed physician with minimum of five (5) years experience in mental health, a Mississippi licensed Psychologist, a Mississippi Licensed Certified Social Worker (LCSW), a Mississippi Licensed Professional Counselor (LPC), a Mississippi Licensed Marriage and Family Therapist (LMFT), a Psychiatric Mental Health Nurse Practitioner under an approved protocol, or a Physician Assistant.

2. For the purpose of this rule, a treatment plan may be referred to as the plan of care, individualized service plan, wraparound plan or person-centered plan depending on the service. It is the plan that directs the treatment of the Medicaid beneficiary.

3. Each initial and updated treatment plan must be reviewed, signed and dated by an approved practitioner as listed in E.1.

4. Each service provided and billed to Medicaid must have corresponding documentation to substantiate the claim, be in the case record and must, at a minimum, include the following documentation:

a) Type of service provided (group therapy, family therapy, individual therapy, etc.),

b) Date (DD/MM/YYYY) of service,

c) Length of time (00:00) spent delivering the service,

d) Time session began and time session ended,

e) Identification of individual (s) receiving or participating in the service,

f) Summary of what transpired in the session,

g) Evidence the session relates to the goals and objectives established in the treatment plan,

h) Name and title of staff who provided the service,

i) Signature and credentials of the person who provided and documented the service, and

j) Legible documentation that can easily be read by reviewers.

5. Community Mental Health services must be documented according to the DMH Record Guide in effect on the date of service for a particular service.

F. Non-covered services

1. The following activities are ineligible for reimbursement by Medicaid:

a) Paperwork completed outside of a direct service provision.

b) Telephone contacts, unless specified in the service definition.

c) Field trips and routine recreational activities.

d) Educational intervention.,

e) Staff travel time.

f) Transportation of individuals receiving mental health services.

g) Beneficiary travel time to or from any CMH service.

h) Failed and/or canceled appointments. The provider is prohibited from billing the Medicaid beneficiary for the missed appointment.

i) Evaluation or review of beneficiary progress outside of treatment team or as a function of targeted case management.

j) CMH services when a beneficiary is an inpatient in an inpatient facility (ex: a medical hospital, an acute freestanding psychiatric facility, or a psychiatric residential treatment facility).

k) Service provided simultaneous with any other Medicaid-covered service, unless specifically allowed in the service definition.

l) Services provided to more than one beneficiary at a time, unless specifically allowed in the service definition.

m) Services in a nursing facility if not approved by the Appropriateness Review Committee as part of the Preadmission Screening and Resident Review Process required by 42 CFR 483, Subpart C.

2. Providers are strongly cautioned not to submit claims for ineligible activities.

Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

Rule 1.2 Psychosocial Assessment and Psychological Evaluation

A. Assessment is the securing, from the beneficiary and/or collateral, of 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 individual's or family's problem(s), the factors contributing to the problem (s), and the most appropriate course of treatment for the beneficiary.

1. A completed Biopsychosocial Assessment form, which includes the signature and credentials of the staff member who conducted the assessment, must be present in the case record.

2. Psychosocial assessment may be completed at the time of intake and as needed for reassessment.

3. All psychosocial assessments must be provided by a staff member who holds a master's degree and professional license (ex:, Physician, Psychologist, Licensed Certified Social Worker, Licensed Master Social Worker, Licensed Professional Counselor or Licensed Marriage & Family Therapist) or who is a DMH Certified Mental Health Therapist, DMH Certified Intellectual and Developmental Disabilities Therapist or a DMH Certified Addiction Therapist (when appropriate for the individual receiving service and the service provided).

4. Those 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.

    a) The supervisor must be of the same discipline as those they supervise (i.e. Mental Health = Mental Health; IDDD= IDDD; Addiction Therapist = Addiction Therapist)

    b) The signature of credentialed supervisor is required on documentation of all services provided.

5. Psychosocial assessment is limited to four (4) assessments per state fiscal year.

B. Psychological Evaluations are the assessment of a beneficiary's cognitive, emotional, behavioral, and social functioning by a licensed psychologist using standardized tests, interviews, and behavioral observations.

1. A psychological evaluation may be eligible for Medicaid reimbursement when one (1) or more of the following conditions exist:

    a) There is a history of unexplained treatment failures.

    b) There are questions regarding diagnosis and/or treatment that a psychological evaluation might help to answer.

    c) Evaluation is required by the Division of Medicaid for admission to a psychiatric residential treatment facility (PRTF).

2. Reasons a psychological evaluation may be eligible for reimbursement include, but are not limited to the following:

    a) The need to confirm or rule out the existence of a major diagnosis, such as depression, psychosis, mental retardation, or Attention Deficit Hyperactivity Disorder (ADHD) when behavioral observation and history supports the suspected diagnosis.

    b) The existence of a pattern of inability to learn, but not to the extent that the beneficiary qualifies for evaluation for Special Education services.

    c) The need to assess a beneficiary's potential for success in a certain type of program.

3. A psychological evaluation is not eligible for reimbursement through Medicaid when any of the following conditions apply:

    a) It is provided as a routine procedure or requirement of any program or provider, including pre-commitment hearings.

b) It is to determine educational needs/problems when such assessment is the responsibility of the school system where the child is enrolled.

c) It is within one (1) year of a previous psychological evaluation, unless necessary for admission to a Medicaid-certified PRTF or community based alternatives to PRTF or if needed to assess progress in a beneficiary with an evolving condition (i.e., head injury, severe depression).

4. Provider Requirements - Psychological evaluations must be completed in their entirety by a psychologist who is licensed to practice independently by the Mississippi Board of Psychology or the licensing board for psychologists in the state the service is provided.

5. Psychological evaluations are limited to four (4) hours per state fiscal year.

6. In order for a psychological evaluation to be eligible for Medicaid reimbursement, the psychologist completing the psychological evaluation must ensure that all of the following occur:

a) Psychological testing is indicated by the referral question. If it is not, it is the responsibility of the psychologist to educate the referral source as to those circumstances in which testing is or is not indicated.

b) An initial session must be held with the beneficiary and beneficiary's family before any testing is initiated. It may occur immediately preceding the psychological testing. The purpose of this session is to determine the medical necessity of psychological evaluation and to gather background information. Collateral contact may be included in the background and information gathering session, and the time spent with those collateral contacts is eligible for Medicaid reimbursement only when that contact is face-to-face. If it becomes apparent during the session that the beneficiary and/or family would benefit from certain strategies/interventions (e.g., bibliotherapy, behavioral approaches for beneficiaries with attention difficulties), these interventions should be implemented and their effectiveness evaluated before the necessity of testing is reconsidered. Though part of the evaluation process, the background and information gathering session should be billed as either a biopsychosocial assessment or family therapy (with or without the beneficiary, as appropriate).

c) The psychologist has appropriate training, experience and expertise to administer, score and interpret those instruments used.

d) The instruments used are psychometrically valid and appropriate to the referral question, the beneficiary's age and any special conditions presented by the beneficiary and/or the testing situation. In those instances in which more than one instrument could be used (e.g., IQ testing), the psychologist chooses the most psychometrically sound one unless otherwise indicated by the unique characteristics of the test-taker (e.g., the beneficiary is non-English speaking, physically unable to manipulate materials).

e) Unless doing so would present a hardship to the beneficiary and family, the beneficiary's family and, when appropriate, the beneficiary are provided with face-to-face (when possible) verbal feedback regarding test results, interpretation and recommendations within fourteen (14) calendar days of the written report. The referral source is included if requested at the time of the referral. The beneficiary's family and the beneficiary shall be given adequate opportunity to ask questions and give their input regarding the evaluation feedback. If face-to-face feedback is not possible, feedback is provided through alternative means. However, as part of the evaluation process, the feedback session should be billed as family therapy, with or without the beneficiary present, as appropriate.

7. Documentation Requirements

a) If/when testing is indicated, the testing process and the written report must document the medical necessity, adequately address the referral question, and reflect an understanding of the background strengths, values and unique characteristics of the beneficiary and family.

b) A written report must be generated within thirty (30) calendar days of completion of the assessment. However, if the beneficiary's treatment needs indicate an earlier report deadline, the report is generated as soon as possible. The report synthesizes the information gathered through interviews, observation, and standardized testing, including a discussion of any cautions related to testing conditions or limitations of the instruments used.

c) The written report must provide practical recommendations for those working with the beneficiary. These recommendations should reflect recognition of the beneficiary and family's strengths as well as their areas of need.

d) If computer-generated scoring or interpretation reports are used as one source of data, they must be integrated into the report as whole. Reports that include computer generated feedback without this integration are unacceptable.

e) Concrete plans are made for follow-up based on evaluation recommendations and feedback from the referral source, the family and, when appropriate, the beneficiary (e.g., therapy appointment is made, the family is given information about mentoring programs), and these plans are documented in writing.

f) Information obtained from collateral contacts is included in the report.

g) Documentation of evaluative services must include the dates and amount of time spent, including beginning and ending session times, in assessment/testing and the amount of time spent preparing a report. Evaluation reports must be dated and signed by the provider who conducted the evaluation.

C. Treatment Plan Review is the process through which a group of clinical staff meets to discuss with the beneficiary and his/her family members the individual's treatment plan. The review will utilize a strengths-based approach and shall address strengths and natural resources, presenting symptoms/problems, diagnostic impressions, and initiate/update a plan of treatment that includes goals, objectives and treatment strategies.

1. Treatment plan reviews must be provided by a team which includes a licensed independent practitioner in accordance with the appropriate scope of practice. These practitioners are limited to: a Mississippi licensed Physician who holds a specialty in psychiatry, a Mississippi licensed Physician with five (5) years experience in mental health, a Mississippi licensed Psychologist, a Mississippi Licensed Certified Social Worker (LCSW), a Mississippi Licensed Professional Counselor (LPC), a Mississippi Licensed Marriage and Family Therapist (LMFT), a Psychiatric Mental Health Nurse Practitioner under an approved protocol, or a Physician Assistant.

2. Treatment plan reviews are limited to four (4) per state fiscal year.

D. Documentation requirements for Treatment Planning

1. The case record must contain documentation of an initial treatment plan developed and reviewed by the treatment team within thirty (30) days of completion of the biopsychosocial assessment, and subsequent reviews as individual case circumstances require, and at least annually. The more frequently any case is reviewed; the documentation must be stronger in the case record justifying the frequency of review.

2. The treatment plan form must be present in the case record and must include, at a minimum:

a) A multi-axial diagnosis (all five (5) axes addressed).

b) Identification of the beneficiaries and/or family's strengths.

c) Identification of the clinical problems or areas of need which are to be the focus of treatment.

d) Treatment goals for each identified need.

e) Treatment objectives that represent incremental progress towards goals, coupled with target dates for their achievement.

f) Specific services, objectives and activities that will be employed to reach each objective.

g) Date of implementation and signatures of the provider and beneficiary.

h) The date of the treatment plan review meeting.

i) The length of time spent in reviewing/planning treatment for the beneficiary.

j) A written report of treatment recommendations/changes resulting from the meeting.

k) The signature of each staff member present when the case was reviewed.

l) Length of meeting time that exceeds one (1) service unit per case must be clearly justified in the case record.

3. Initial treatment plan and all subsequent treatment plans must be reviewed by treatment team and recommendations clearly documented.

Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

Rule 1.3 Psychotherapeutic Services

A. Psychotherapeutic services are defined as intentional, face-to-face interactions (conversations or non-verbal encounters, such as play therapy) 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.

B. Individual Therapy is defined as one-on-one psychotherapy that takes place between a mental health therapist and a beneficiary. Individual therapy is limited to thirty-six (36) sessions per state fiscal year.

C. Family Therapy is defined as psychotherapy that takes place between a mental health therapist and a beneficiary's family members, with or without the presence of the beneficiary. Family therapy may also include others (Department of Human Services (DHS) staff, foster family members, etc.) with whom the beneficiary lives or has a family-like relationship. This service includes family psychotherapy, psychoeducation, and family-to-family training. Family therapy is limited to twenty four (24) sessions per state fiscal year.

D. Group Therapy is defined as psychotherapy that takes place between a mental health therapist and at least two (2) but no more than ten (10) children or at least two (2) but no more that twelve (12) adults at the same time. Possibilities include, but are not limited to, groups that focus on relaxation training, anger management and/or conflict resolution, social skills training, and self-esteem enhancement.

1. Group therapy is not eligible for Medicaid reimbursement on the same day as any psychosocial rehabilitation service, day support, day treatment service, acute partial hospitalization or crisis residential.

2. Group therapy is limited to forty (40) sessions per state fiscal year.

E. Multi-Family Group Therapy is defined as psychotherapy that takes place between a mental health therapist and family members of at least two (2) different beneficiaries, with or without the presence of the beneficiary, directed toward the reduction/resolution of identified mental health problems so that the beneficiaries and/or their families may function more independently and competently in daily life. This service includes psychoeducational and family-to-family training. Multi-family therapy is limited to forty (40) sessions per state fiscal year and that limit includes group therapy and multi-family group therapy.

F. Provider Requirements

1. All services under this category must be provided by a staff member who holds a master's degree and professional license (ex:, Physician, Psychologist, Licensed Certified Social Worker, Licensed Master Social Worker, Licensed Professional Counselor or Licensed Marriage & Family Therapist) or who is a DMH Certified Mental Health Therapist, DMH Certified Intellectual and Developmental Disabilities Therapist or a DMH Certified Addiction Therapist (when appropriate for the individual receiving service and the service provided).

2. Those 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.

   a) The supervisor must be of the same discipline as those they supervise (i.e. Mental Health = Mental Health; IDDD= IDDD; Addiction Therapist = Addiction Therapist)

   b) The signature of credentialed supervisor is required on documentation of all the services provided.

3. If evidence–based practices (EBP) or evidence-informed best practices such as Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) are employed in the course of treatment, they 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: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

Rule 1.4 Day Programs

A. Psychosocial Rehabilitation is an active treatment program designed to support and restore community functioning and well-being of an adult Medicaid beneficiary who has been diagnosed with a serious and persistent mental disorder. Psychosocial rehabilitation programs must use systematic, curriculum based interventions for skills development for participants. Its purpose is to promote recovery in the individual's community by alleviating psychiatric decompensation, confusion, anxiety, feelings of low self-worth, isolation and withdrawal. Program activities aim to improve reality orientation, social adaptation, physical

coordination, daily living skills, coping skills, effective management of time and resources, task completion and activities to incorporate the individual into independent community living. It is oriented toward empowerment, recovery and competency.

1. Psychosocial Rehabilitation may be provided to adults with a serious and persistent mental illness.

2. Psychosocial Rehabilitation must be provided in a program certified by the Department of Mental Health.

3. Psychosocial Rehabilitation is the most intensive day program available for adults. It is designed to support individuals who require extensive clinical services to support community inclusion and prevent re-hospitalization.

4. Psychosocial Rehabilitation must be provided by a program which has at least one (1) clinical staff member present during the time of program operation.

    a) Clinical staff member is defined as a staff member who holds a master's degree and professional license (ex:, Physician, Psychologist, Licensed Certified Social Worker, Licensed Master Social Worker, Licensed Professional Counselor or Licensed Marriage & Family Therapist) or who is a DMH Certified Mental Health Therapist, DMH Certified Intellectual and Developmental Disabilities Therapist or a DMH Certified Addiction Therapist (when appropriate for the individual receiving service and the service provided).

    b) Those 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.

        1) The supervisor must be of the same discipline as those they supervise (i.e. Mental Health = Mental Health; IDDD= IDDD; Addiction Therapist = Addiction Therapist)

        2) The signature of credentialed supervisor is required on documentation of all services provided.

5. Beneficiaries may participate in psychosocial rehabilitation up to five (5) hours per day, up to five (5) days per week.

6. Psychosocial Rehabilitation services must be prior authorized by the Division of Medicaid or its designee, effective for dates of service on or after July 1, 2012.

7. Psychosocial Rehabilitation services are not eligible for Medicaid reimbursement on the same day as group therapy, day support, senior psychosocial rehabilitation, crisis residential or acute partial hospitalization.

8. Documentation Requirements

    a) The case record must contain a monthly progress summary for each beneficiary that includes:

        1) Notation of each date the service was provided,

        2) The length of time the service was provided on each date, and

        3) A summary of the beneficiary's progress that relates to the goals and objectives established on the Treatment Plan.

B. Day Support is a program of structured clinical activities in a group setting designed to support and enhance the role functioning of adult Medicaid beneficiaries who are able to live fairly independently in the community through the regular provision of structured therapeutic support. Program activities aim to improve beneficiaries' reality orientation, social adaptation, physical coordination, daily living skills, time and resource management, and task completion as well as to alleviate such psychiatric symptoms as confusion, anxiety, isolation, withdrawal and feelings of low self-worth. The activities provided must include, at a minimum, the following: group therapy, individual therapy, social skills training, coping skills training, and training in the use of leisure-time activities. Day Support programs must provide active clinical treatment in a group setting.

1. Beneficiaries may participate in Day Support for a maximum of five (5) hours per day, a maximum of five (5) days per week. This program is the least intensive psychosocial rehabilitation service available.

2. Day Support Services may be provided to individuals with a Serious and Persistent Mental Illness or Substance Abuse diagnosis. It may be provided to individuals with intellectual and developmental disabilities through June 30, 2012.

3. Day Support must be provided by a program which has at least one clinical staff member responsible for planning and directly supervising program operation.

    a) Clinical staff member is defined as a staff member who holds a master's degree and professional license (ex:, Physician, Psychologist, Licensed Certified Social Worker, Licensed Master Social Worker, Licensed Professional Counselor or Licensed Marriage & Family Therapist) or who is a DMH Certified Mental Health Therapist, DMH Certified Intellectual and Developmental Disabilities Therapist or a DMH Certified Addiction Therapist (when appropriate for the individual receiving service and the service provided).

    b) Those 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.

(1) The supervisor must be of the same discipline as those they supervise (i.e. Mental Health = Mental Health; IDDD= IDDD; Addiction Therapist = Addiction Therapist)

4. The signature of credentialed supervisor is required on documentation of all services provided.

5. Day Support services must be prior authorized by the Division of Medicaid or its designee for dates of service on or after July 1, 2012.

6. Day support services are not eligible for Medicaid reimbursement on the same day as group therapy, clubhouse, senior psychosocial rehabilitation, crisis residential or acute partial hospitalization.

7. Documentation Requirements

   a) The case record must contain a progress summary for each beneficiary that includes:

      1) Notation of each date the service was provided,

      2) The length of time the service was provided on each date, and

      3) A summary of the beneficiary's progress that relates to the goals and objectives established on the Treatment Plan.

C. Senior Psychosocial Rehabilitation is a program of structured activities designed to support and enhance the ability of senior Medicaid beneficiaries to function at the highest possible level of independence in the most integrated setting appropriate to their needs. The activities target the specific needs and concerns of the senior while aiming to improve beneficiaries' reality orientation, social adaptation, physical coordination, daily living skills, time and resource management, task completion and other areas of competence that promote independence in daily life. Activities are designed to alleviate such psychiatric symptoms as confusion, anxiety, disorientation, distraction, preoccupation, isolation, withdrawal and feelings of low self-worth.

1. Beneficiaries may participate in Senior Psychosocial Rehabilitation for a maximum of five (5) hours per day, a maximum of five (5) days per week.

2. Senior Psychosocial Rehabilitation may be provided to adults age fifty (50) and older with a diagnosis of a serious and persistent mental illness. It may be provided to individuals with intellectual and developmental disabilities through June 30, 2012.

3. Senior Psychosocial Rehabilitation must be provided by a program which has at least one clinical staff member present during the time of program operation.

a) Clinical staff member is defined as a staff member who holds a master's degree and professional license (ex:, Physician, Psychologist, Licensed Certified Social Worker, Licensed Master Social Worker, Licensed Professional Counselor or Licensed Marriage & Family Therapist) or who is a DMH Certified Mental Health Therapist, DMH Certified Intellectual and Developmental Disabilities Therapist or a DMH Certified Addiction Therapist (when appropriate for the individual receiving service and the service provided).

b) Those 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.

(1) The supervisor must be of the same discipline as those they supervise (i.e. Mental Health = Mental Health; IDDD= IDDD; Addiction Therapist = Addiction Therapist)

(2) The signature of credentialed supervisor is required on documentation of all services provided.

4. Senior Psychosocial Rehabilitation services provided in a nursing facility must also be authorized through the Preadmission Screening and Resident Review (PASRR) rules.

5. Senior psychosocial rehabilitation services provided in the community for individuals who are not residents of a nursing facility must be prior authorized by the Division of Medicaid or its designee for dates of service on or after July 1, 2012.

6. Elderly psychosocial services are not eligible for Medicaid reimbursement on the same day as group therapy, day support, psychosocial rehabilitation, crisis residential or acute partial hospitalization.

7. Documentation Requirements

a) The case record must contain a progress summary for each beneficiary that includes:

(1) Notation of each date the service was provided,

(2) The length of time the service was provided on each date, and

(3) A summary of the beneficiary's progress that relates to the goals and objectives established on the Treatment Plan.

D. Day Treatment is a behavioral intervention program, provided in the context of a therapeutic milieu, which provides primarily school age children/adolescents with serious emotional disturbances (SED) the intensity of treatment necessary to enable them to live in the community. The program is based on behavior management principles and includes, at a minimum, positive feedback, self-esteem building and social skills training. Additional

components are determined by the needs of the participants in a particular program and may include skills training in the areas of impulse control, anger management, problem solving, and/or conflict resolution. The most important element of Day Treatment is the consistency and qualifications of the staff providing the service. Day Treatment is the most intensive outpatient program available to children and adolescents. It provides an alternative to residential treatment or acute psychiatric hospitalization and/or serves as a transition from these services.

1. Beneficiaries may participate in the program a maximum of five (5) hours per day, five (5) days per week with a minimum of four hours per week.

2. Day Treatment may be provided to children with SED.

3. No less than four (4) individuals may participate in a Day Treatment program in order to achieve a therapeutic milieu.

4. No Day Treatment room shall have more than ten (10) individuals with emotional and/or behavior disorders participating in the program at any time.

   If programs are developed for individuals with a diagnosis of Autism/Asperger's are developed around youth who meet medical necessity criteria, there shall be no more than four (4) individuals with a diagnosis of Autism/Asperger's per program.

5. In order to participate in the Day Treatment program, a child or youth must be on the permanent roster for the program. They shall not participate on an intermittent basis.

6. Day Treatment must include involvement of the family or individuals acting in loco parentis as often as possible, but not less than twice per month, in order to achieve improvement that can be generalized across environments.

7. Day Treatment Services are not eligible for Medicaid reimbursement on the same day as group therapy, crisis residential or acute partial hospitalization.

8. Day Treatment must be prior authorized by the Division of Medicaid or its designee for dates of service on or after July 1, 2012.

9. Day Treatment services must be provided by a non-case management staff member who holds a Master's Degree and professional license (ex: Licensed Certified Social Worker, Licensed Marriage & Family Therapist, Licensed Professional Counselor, Psychologist, Licensed Master Social Worker, or a Medical Doctor) or who is a DMH Certified Mental Health Therapist or DMH Provisionally Certified Mental Health Therapist.

10. The staff person providing day treatment services must also provide other therapy services for the children and youth in day treatment, which are deemed medically necessary whenever possible.

11. Documentation Requirements

a) The case record must contain progress notes for each beneficiary.

b) The progress notes must include:

1) Date the service was provided,

2) Length of time the service was provided on each date, and

3) A summary of the beneficiary's progress that relates to the goals and objectives established on the Treatment Plan.

E. Acute Partial Hospitalization is 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 to outpatient 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.

1. Acute Partial Hospitalization may be provided to children with SED or adults with SPMI.

2. Acute Partial Hospitalization must be prior authorized by the Division of Medicaid or its designee for dates of service on or after July 1, 2012.

3. Acute Partial Hospitalization programs must be certified by the Department of Mental Health.

4. Acute Partial Hospitalization programs must have medical supervision and nursing services immediately available during hours of operation.

5. Acute Partial Hospitalization is limited to one hundred (100) days per state fiscal year.

6. Documentation requirements:

a) The case record must contain a physician order for the service stating that inpatient care would be necessary without the service.

b) The case record must contain a daily progress summary for each beneficiary which meets the documentation criteria for acute partial hospitalization services.

Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

Rule 1.5 Crisis Services

A. Crisis Response Services

1. Crisis Response Services - Time limited intensive intervention, available twenty-four (24) hours a day, seven (7) days a week. Crisis response services allow for the assessment of the crisis and ability to activate a mobile crisis team. Trained crisis response staff provides crisis stabilization and treatment of a Medicaid eligible individual directed toward preventing hospitalization. Children or adults requiring crisis services are those who are experiencing a significant emotional/behavioral crisis. A crisis situation is defined as a situation in which an individual's mental health and/or behavioral health needs exceed the individual's resources, in the opinion of the mental health professional assessing the situation.

    a) Crisis Response services are considered community based services and must be available face-to-face whenever the beneficiary and their family is in need of crisis response services. Initial crisis response may be provided by telephone.

    b) Crisis Response services are available to adults exhibiting symptomology indicating a serious and persistent mental illness or children and youth exhibiting symptomology indicating a serious emotional disturbance.

    c) Crisis Response services may be provided in the emergency department of a hospital.

    d) Crisis Response services may be provided prior to an individual being "admitted" to services with a service provider. Individuals needing crisis services will not be required to have an "intake" or "biopsychosocial assessment" prior to receiving crisis services. They may be "admitted" to services secondary to a crisis response service.

2. Provider requirements

    a) All services under this Rule must be provided by a staff member who holds a Master's degree and professional license (ex:, Physician, Psychologist, Licensed Certified Social Worker, Licensed Master Social Worker, Licensed Professional Counselor or Licensed Marriage & Family Therapist) or who is a DMH Certified Mental Health Therapist.

    The Division of Medicaid does not provide reimbursement for crisis response services provided by provisionally certified staff.

    b) Medical professionals must be available by phone to the staff member providing crisis response services including, at a minimum, a licensed registered nurse and psychiatry professional who is licensed as one of the following:

        1) Board-certified Psychiatrist, or

2) Psychiatric mental health nurse practitioner, or

3) Physician assistant with two (2) years' experience in the practice of psychiatry.

c) All staff members providing crisis response services must obtain and maintain certification in a professionally recognized method of crisis intervention and de-escalation, such as Techniques for Managing Aggressive behavior, the Mandt system or Nonviolent Crisis Intervention.

3. Documentation requirements

Progress notes must clearly document that the crisis services provided are necessary to maintain the child or adult in the least restrictive and most appropriate, environment.

B. Crisis Residential is a residential program that provides medical supervision, nursing services, structured therapeutic activities, and intensive psychotherapy (individual, family and/or group) at a facility based site. Services are provided to beneficiaries who are experiencing a period of such acute distress that their ability to cope with normal life circumstances is severely impaired. Crisis Residential is designed to prevent inpatient hospitalization, address acute symptoms, distress, and further decomposition, and also help transition from hospitalization to community based services. Program content may vary based on beneficiary need but must include close observation/supervision and intensive support with the focus on reduction/elimination of acute symptoms.

1. Crisis residential may be provided to children or youth with serious emotional/behavioral disturbance or adults with a serious and persistent mental illness.

2. Crisis residential must be ordered by a psychiatrist, psychiatric mental health nurse practitioner or licensed psychologist.

3. Crisis residential must be prior authorized by the Division of Medicaid or its designee for dates of service on or after July 1, 2012.

4. Services must be provided at a facility licensed to service no more than sixteen (16) individuals at a time.

5. Medicaid reimbursement for crisis residential does not include room and board costs.

6. Crisis residential is limited to sixty (60) days per state fiscal year.

7. A psychiatrist, psychiatric mental health nurse practitioner or psychologist must be at the location of the crisis residential program and immediately available if needed.

8. Documentation Requirements

a) Medical services must be documented according to industry standard for medical hospitals.

b) Other clinical services must be documented according to the DMH Record Guide.

Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

Rule 1.6 Community Support Services

A. Community Support Services (CSS) provides an array of support services delivered by community based mobile professionals. Services address the individualized mental health needs of the client. They are directed towards adults, children, adolescents and families and will vary with respect to hours, type and intensity of services, depending on the changing needs of each individual. The purpose/intent of CSS is to provide specific, measurable, and individualized services to each person served. CSS should be focused on the individual'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. This service replaces the direct services historically provided as case management in Mississippi.

1. Community Support Services are services that can be provided to/for the individual by the CSS Specialist in any setting within the community absent from being involved in any other Medicaid reimbursable service simultaneously. The CSS Specialist not only assists the individual in gaining access to needed services necessary for community integration and sustainability within the community, but may also provide some of those direct services themselves, such as supportive counseling/reality orientation, skills training, enlisting social supports, financial management counseling, monitoring physical and mental health status, etc.

    a) Community support services are defined as services that are specific, measurable, and individualized that focus on the individual'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. These shall include the following as clinically indicated:

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

        2) Individual therapeutic interventions with a beneficiary 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 on the identification and self-management of prescribed medication regimen and communication with the prescribing provider.

5) Direct interventions in deescalating 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) Psychoeducation and training of family, unpaid caregivers, and/or others who have a legitimate role in addressing the needs of the individual.

9) Facilitation of the Individual Service Plan which includes the active involvement of the beneficiary and the people identified as important in the person's life.

2. Community support services are limited to four hundred (400) units (15 minute unit) per state fiscal year and six (6) per day.

3. Provider requirements

a) Community Support Services must each be provided by a staff member who holds a minimum of at least a Bachelor's Degree in mental health.

b) The provider of this service must be provisionally certified by the DMH as a Certified Community Support Specialist within six (6) months of their hire date. The professional who provides these services will be known as the Community Support Specialist (CSS). The DMH certification for Case Management Professionals will be accepted for dates of service prior to January 1, 2013.

c) Supervision for services under this Rule must be provided by a staff member who holds a Master's degree and professional license (ex:, Physician, Psychologist, Licensed Certified Social Worker, Licensed Master Social Worker, Licensed Professional Counselor or Licensed Marriage & Family Therapist) or who is a DMH Certified Mental Health Therapist, or a DMH Certified Addiction Therapist (when appropriate for the individual receiving service and the service provided). Supervision may not be provided by a staff member who is provisionally certified.

4. Documentation Requirements

Progress notes must clearly document that the Community Support Services provided are medically necessary to maintain the child or adult in the least restrictive, yet appropriate environment within the community and must relate back to the treatment plan/service plan.

Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

Rule 1.7 Peer Support Services

A. Peer Support Services are 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. Peer Support Service is a helping relationship between peers and/or family member(s) that are directed toward the achievement of specific goals defined by the consumer. It may also be provided as a family partner role.

1. Peer Support Services are face-to-face interventions with the consumer or family present.

2. Provider Requirements

a) Services must be rendered by a peer specialist certified by the Department of Mental Health using a certified curriculum.

b) Peer support specialists must receive annual training in a recognized peer training program recognized by DMH.

c) Peer support specialists must possess a high school diploma or GED equivalent. For young adults ages sixteen to twenty (16-20) years, peer support specialists must be enrolled and attending school or in the process of obtaining a Test of General Education Development (GED).

d) Peer support specialists must be a current or former consumer/first degree family member of an individual who has received treatment for and self-identify as a current or former mental health consumer and/or family member.

e) Staff must have completed an appropriate training program, such as family-to-family or Family Time Out.

f) Peer support specialists will have, during the last year, demonstrated a minimum of six (6) months in self-directed recovery.

g) Peer support services are limited to two hundred (200) units (15 minute unit) per state fiscal year.

h) Peer support services must be supervised by a Peer Support Services Supervisor with a minimum of a Master's degree and who has received basic Peer Specialist training specifically developed for supervision within the Peer Specialist program, as provided by DMH.

3. Documentation Requirements

Peer Support Services must be included in and coordinated with the individual's treatment plan with a specific planned frequency for patients who the physician and/or mental health professional believes would benefit from this recovery support process.

Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

Rule 1.8 Wraparound Facilitation

A. Wraparound Facilitation is the creation and facilitation of a child and family team for the purpose of developing a single plan of care to address the needs of youth with complex mental health challenges and their families. The child and family team will meet regularly to monitor and adjust the plan of care if necessary or progress is not being made. Wraparound facilitation is intended to serve individuals who have serious mental health challenges that exceed the resources of a single agency or service provider, experienced multiple acute hospital stays, at risk of out-of-home placement or have been recommended for residential care or 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.

   Wraparound facilitation must be provided in accordance with high fidelity and quality wraparound practice.

   1. Services are comprised of a variety of specific tasks and activities designed to carry out the wraparound process, including:

      a) Engaging the family,

      b) Assembling the child and family team,

      c) Facilitating a child and family team meeting at minimum every thirty (30) days,

      d) Facilitating the creation of a plan of care, which includes a plan for anticipating, preventing and managing crisis, within the child and family team meeting,

      e) Working with the team in identifying providers of services and other community resources to meet family and youth needs,

      f) Making necessary referrals for youth,

      g) Documenting and maintaining all information regarding the plan of care, including revisions and child and family team meetings,

      h) Presenting plan of care for approval,

i) Providing copies of the plan of care to the entire team including the youth and family/guardian,

j) Monitoring the implementation of the plan of care and revising if necessary to achieve outcomes,

k) Maintaining communication between all child and family team members,

l) Monitoring the progress toward need met and are the referral behaviors decreasing,

m) Leading the team to discuss and ensure the supports and services the youth and family are receiving continue to meet the caregiver and youth's needs,

n) Educating new team members about the wraparound process, and

o) Maintaining team cohesiveness.

2. Child and family team membership must include:

   a) The wraparound facilitator,

   b) The child's service providers, any involved child 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) Identified youth, if age nine (9) or above, unless there are clear clinical indications this would be detrimental. Such reasons must be documented clearly throughout the record.

3. Wraparound facilitation is limited to one hundred (100) units (15 minute unit) per state fiscal year and eight (8) units per day.

4. Provider requirements

   a) Wraparound facilitators and supervisors of the process must have completed Introduction to Wraparound 3-day training.

   b) Wraparound facilitators and supervisors must participate in ongoing coaching and training as defined by the Division of Medicaid.

c) The provider organization or CMHC providing Wraparound facilitation must be participating in the wraparound certification process through the Division of Medicaid or its designee.

d) Providers must ensure case load size for wraparound facilitators is maintained at an average of not more than ten (10) cases per wraparound facilitator.

Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

Rule 1.9 Medical Services

A. Medication Evaluation & Monitoring

1. Medication Evaluation & Monitoring is the intentional face-to-face interaction (including telehealth transmisssions) between a physician, physician assistant, or a nurse practitioner and a beneficiary for the purpose of:

   a) Assessing the need for psychotropic medication,

   b) Prescribing medications, and

   c) Regular periodic monitoring of the medications prescribed for therapeutic effect and medical safety.

2. Medication Evaluation & Monitoring Services must be provided by a:

   a) Licensed physician,

   b) Doctor of osteopathy,

   c) Psychiatric mental health nurse practitioner, or

   d) Physician assistant with two (2) years psychiatric training

3. Medical monitoring of psychotropic medications must include lab testing for medical side effects as recommended in package insert and as is the standard of care.

4. Medication evaluation & management may be provided by the use of telehealth.

5. Medication evaluation & management is limited to a total of seventy-two (72) services per state fiscal year when combined with the psychiatric interview and therapy with medication management.

6. Documentation Requirements

Medication(s) prescribed must be documented on the Medication Profile sheet in the case record.

B. Nursing Assessment

1. Nursing Assessment takes place between a registered nurse and a beneficiary for the purpose of assessing extra-pyramidal symptoms, medication history, medical history, progress on medication, current symptoms, progress or lack thereof since last contact and providing education to the beneficiary and the family about the illness and the course of available treatment.

2. Nursing assessment is limited to one hundred forty-four (144) units (15 minute units) per state fiscal year and four (4) units per day.

3. Provider requirements

   a) Nursing Assessment must be provided by, at a minimum, a registered nurse.

   b) A physician, doctor of osteopathy, nurse practitioner, physician assistant, and psychiatric mental health nurse practitioner are also eligible providers.

4. Current medication(s) must be documented on the Medication Profile sheet in the case record.

C. Injectable medication is provided in a physician's office or community mental health center for the purpose of restoring, maintaining or improving the beneficiary's role performance and/or mental health status.

1. Mississippi Medicaid provides coverage for injectable drugs when they are administered in a clinically appropriate manner. If a portion of the drug in a single use or multiple dose use vial must be discarded, DOM will not reimburse for the discarded amount of the drug.

2. Providers may not bill Mississippi Medicaid beneficiaries for the discarded drug.

3. Injections shall be administered by a licensed physician, psychiatric mental health nurse practitioner, physician assistant, registered nurse or licensed practical nurse.

4. Documentation Requirements

   a) The case record must contain a specific physician's order for the service.

   b) The case record must contain documentation of the following:

      1) The date of each injection,

2) The name of the medication,

3) The dosage, and

4) The site of injection.

5. The documentation must be authenticated by the signature and credentials of the person who gave the injection.

Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

Rule 1.10 Program of Assertive Community Treatment

A. Assertive Community Treatment

Assertive Community Treatment (ACT/PACT) is a multi–disciplinary, self-contained clinical team approach providing comprehensive mental health and rehabilitative services. Team members provide long-term intensive care in natural community settings. The team provides all mental health services rather than referring individuals to different mental health providers, programs, and other agencies. Major activities under ACT/PACT may include: client specific treatment team planning – team meets daily to plan services, assesses individuals community status and share information to coordinate services; individual supports – for activities of daily living, financial management, skills training, medication support; coordination with collaterals – sharing information with healthcare and other providers; individual clinical interventions – therapy, diagnosis and assessment.

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

2. The aim of PACT is to address the varied needs of adults with serious and persistent mental illness in a mobile treatment team approach/ environment.

3. PACT services include a self-contained treatment milieu based on the level of need of the individual.

4. PACT services allow concurrent service provision by more than one PACT staff member when clinically indicated and substantiated in the documentation.

5. PACT services are limited to sixteen hundred (1600) units (15 minute unit) per state fiscal year and forty (40) units per day.

6. PACT services must be prior authorized by the Division of Medicaid or its designee, for dates of service on or after July 1, 2012.

7. Services include:

    a) Psychiatric service/assessment/treatment (including telepsychiatry);

    b) Nursing;

    c) Peer support;

    d) Medication monitoring/evaluation;

    e) Vocational;

    f) Transportation;

    g) Housing;

    h) Employment services; and

    i) Administrative case management.

8. Provider requirements

    a) ACT/PACT Teams must be certified by the Department of Mental Health and maintain all standards set forth by the Department of Mental Health.

    b) ACT/PACT Services must be provided by staff members who are certified/qualified/ credentialed/ licensed to provide the service required.

9. Non-covered services

    a) Beneficiaries enrolled in ACT/PACT programs cannot receive community based mental health services from any provider other than an ACT/PACT provider.

    b) Beneficiaries enrolled in ACT/PACT may not receive psychosocial rehabilitation, senior psychosocial rehabilitation, or day support.

10. Documentation Requirements

    a) All documentation must meet the requirements set forth by the DMH minimum standards.

    b) The case record must also contain:

        1) A daily progress summary for each beneficiary which meets the documentation criteria for PACT daily total of time spent with the beneficiary.

2) The case record must contain a physician's order for the service stating that inpatient care would be necessary without the service.

3) A written report of treatment recommendations/changes resulting from a treatment plan review and the signature of each staff present when the case was reviewed.

Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

Rule 1.11 Intensive Outpatient Psychiatric

A. Intensive Outpatient Psychiatric is family stabilization and intensive outpatient psychiatric treatment provided to children and youth with serious emotional disturbance. Time-limited intensive family preservation intervention intended to diffuse the current crisis, evaluate its nature, and intervene to reduce the likelihood of a recurrence. The ultimate goal is to stabilize the living arrangement, promote reunification or prevent the utilization of out-of-home therapeutic resources (i.e., psychiatric hospital, therapeutic foster care, and residential treatment facility).

1. In order to receive Intensive Outpatient Psychiatric services, individuals must meet all the following criteria:

a) The youth has been 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 DSM-IV on Axis I. The primary diagnosis must be on Axis I.

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

c) The evaluating psychiatrist or licensed psychologist advises that the youth meets criteria for PRTF level of care.

d) The youth needs specialized services and supports from multiple agencies including case management, and an array of clinical interventions and family supports.

2. Providers of intensive outpatient psychiatric services must meet the following requirements:

a) Hold certification by DMH to provide case management services;

b) Have a psychiatrist on staff;

c) Have appropriate clinical staff to provide therapy services needed,

d) Inform DOM in writing of any critical incidents (life-threatening, allegations of staff misconduct, abuse/neglect) and describes staff management of the incident,

e) Inform the participant/family of grievance and appeals procedures,

f) Report all grievances and appeals to the Division of Medicaid,

g) Has staff who meets the Division of Medicaid qualifications for the category of service they provide, and

h) Be a qualified provider of wraparound facilitation.

3. Providers must have procedures in place for twenty-four (24) hour, seven (7) day a week availability and response.

4. Intensive outpatient psychiatric is limited to two hundred seventy (270) days of service provision per state fiscal year.

5. Intensive outpatient psychiatric is only eligible for reimbursement on the date a service is provided.

6. Intensive outpatient psychiatric is an all inclusive service designed to meet the clinical needs of the children/youth and families. Component parts of the service are not eligible for separate reimbursement on the same day as intensive outpatient psychiatric.

7. Intensive Outpatient Services require prior authorization by the Division of Medicaid or its designee for dates of service on or after July 1, 2012.

8. Each beneficiary receiving intensive outpatient psychiatric services must have on file an individualized service plan which describes the following:

   a) Services to be provided,

   b) Frequency of service provision,

   c) Who provides each service and their qualifications,

   d) Formal and informal support available to the participant and family, and

   e) Plan for anticipating, preventing and managing crises.

Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

Rule 1.12 Treatment Foster Care

A. Treatment Foster Care (TFC) services are intensive and supportive services provided to children in Department of Human Services (DHS) custody or at-risk of having DHS obtain custody with significant medical, developmental, emotional, or behavioral needs, who with additional resources, can remain in a family setting and achieve positive growth and development. Service includes specialized training, clinical support, and in-home intervention to treatment foster parents and the child, allowing the child to remain in a family home setting. Payment for TFC services are not inclusive of room and board payment.

1. Treatment Foster Care is an intensive community-based program composed of mental health professional staff and trained foster parents who provide a therapeutic program for children and youth with serious emotional disturbances living in a licensed therapeutic foster home.

2. Treatment foster care must be approved by the Department of Human Services

3. Treatment Foster Care must be prior authorized by the Division of Medicaid or its designee.

4. Treatment Foster Care is limited to three hundred sixty five (365) days per state fiscal year.

5. Each licensed TFC home must not have more than (1) child or youth with SED at any given time. Siblings with SED may be placed together in the same TFC home.

6. Provider requirements

    a) Treatment foster care programs must be certified by the Department of Mental Health.

    b) Provider must have available a licensed psychiatrist with experience working with children/youth.

    c) All clinical services must be provided by a staff member who holds a Master's degree and professional license (ex:, Physician, Psychologist, Licensed Certified Social Worker, Licensed Master Social Worker, Licensed Professional Counselor or Licensed Marriage & Family Therapist) or who is a DMH Certified Mental Health Therapist, DMH Certified Intellectual and Developmental Disabilities Therapist or a DMH Certified Addiction Therapist (when appropriate for the individual receiving service and the service provided).

B. TFC programs must provide mental health services for all children in the program in the following manner and those services are included in the TFC service:

1. Individual therapy one (1) session per week with child/youth,

2. A minimum of two (2) family sessions per month with the therapeutic foster parents,

3. Face-to-face contact with TFC parents at least two (2) times a month, with at least one (1) of the two (2) contacts in the home,

4. TFC support groups once a month,

5. Annual psychiatric evaluation, and

6. Twenty four (24) hour per day and seven (7) days a week emergency services and crisis intervention.

C. Non-covered services

Providers of Treatment Foster Care Services shall not bill Medicaid separately for the component parts of Treatment Foster care listed in 2.4.B of this rule.

Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

Rule 1.13 Multi-Systemic Therapy

A. Multi-systemic therapy (MST) for youth in the juvenile justice system is an evidence-based practice of a strengths intensive family-and community-based treatment program that focuses on the entire world of chronic juvenile offenders — their homes and families, schools and teachers, neighborhoods and friends. MST interventions work to increase the caregivers' parenting skills, improve family relations, involve the youth with friends who do not participate in criminal behavior, help him or her get better grades or start to develop a vocation, help the adolescent participate in positive activities, such as sports or school clubs, create a support network of extended family, neighbors and friends to help the caregivers maintain the changes.

1. MST Services include:

a) An initial assessment to identify the focus of the MST intervention,

b) Individual therapeutic interventions with the youth and family,

c) Peer interventions,

d) Case management,

e) Crisis stabilization, and

f) Specialized therapeutic interventions to address areas such as substance abuse, sexual abuse, sex offending, and domestic violence, when needed.

2. Services must be available in-home, at school and in other community settings

3. MST services are delivered in a team approach designed to address the identified needs of children and adolescents with significant behavioral problems who are transitioning from out of home placements or are at-risk of out-of-home placement and need intensive interventions to remain stable in the community.

4. MST services must be ordered by a physician, licensed psychologist, physician's assistant or nurse practitioner.

5. MST services allows for collateral contacts and phone contact.

6. MST services must be prior authorized by the Division of Medicaid or its designee.

7. MST services are limited to three hundred twelve (312) units (15 minute unit) per state fiscal year and eight (8) units per day.

8. Provider qualifications:

   a) MST services must be delivered by practitioners employed by an agency.

   b) Within three (3) years of enrollment as a provider, the agency must have achieved national accreditation in MST.

   c) Providers must have the availability of crisis response on a twenty-four (24) hours a day, seven (7) days a week.

   d) Staff providing MST services must participate in MST introductory training and ongoing training and consultation as required by the Division of Medicaid.

   e) The MST program must have a team supervisor who is a Master's level or above professional or has a minimum at least two (2) years of experience in mental health or child welfare services.

   f) MST Therapists must be full-time, MST dedicated Masters-level staff.

   g) MST team member to family ration shall not exceed a one (1) to five (6) ratio.

Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

Rule 1.14 Targeted Case Management

A. Targeted Case Management is defined as services that provide information/referral and resource coordination to the beneficiary and/or his/her collaterals. Case Management Services are directed towards helping the beneficiary maintain his/her highest possible level of independent functioning. Case managers monitor the treatment plan and ensure team members complete tasks that are assigned to them, that follow up and follow through occur and help identify when the treatment team my need to review the treatment plan for updates if the established plan is not working.

1. Targeted case management may be provided face-to- face or via telephone.

    a) Targeted case management is not designed to be a mobile service, but there is no prohibition on services being provided in a location other than the community mental health center.

    b) If services are provided at another location, travel time is not a covered service.

2. Targeted case management must be provided by, at a minimum, a licensed social worker (LSW) with two (2) years' experience in mental health or a registered nurse (RN) with two (2) years' experience in mental health.

3. Targeted case management must be included in the individual's treatment plan.

4. The frequency of case management services will be determined by the complexity of the case and the need of the beneficiary, but shall not occur less than once monthly.

5. Targeted case management services are limited to two hundred sixty (260) units (15 minute unit) per state fiscal year.

Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

Rule 1.15 School Based Services

A. School Based Services are covered by the Division of Medicaid for dates of service through June 30, 2012. As of July 1, 2012, School-based services as defined in this rule will no longer be covered by Medicaid. Mental health services provided in the school setting will be covered as Community Support Services or other therapy services, as appropriate based on the individual need.

B. School-based services are professional therapeutic services provided in a school setting that is more intensive than traditional case management services. School based services include consultation and crisis intervention. School-Based Services may be provided to SED and MR/DD children.

1. Consultation is professional advice and support provided by a therapist to a child's teachers, guidance counselors, and other school professionals, as well as to parents,

community support providers, treatment teams, court systems, etc. Consultation may be provided as a form of early intervention when no formal treatment process has been established. Parent and/or teacher conferences are included in this service component.

2. Crisis Intervention is therapeutic engagement at a time of internal or external turmoil in a child's life with a focus on producing effective coping. Crisis intervention strategies may be directed toward alleviating immediate personal distress, assessing the precipitants that produced the crisis, and /or developing preventative strategies to reduce the likelihood of future similar crises. This service may be provided to family members when their involvement relates directly to the identified needs of the child.

3. All services under this category must be provided by a staff member who holds a master's degree and professional license (ex:, Physician, Psychologist, Licensed Certified Social Worker, Licensed Master Social Worker, Licensed Professional Counselor or Licensed Marriage & Family Therapist) or who is a DMH Certified or Provisionally Certified Mental Health Therapist, DMH Certified or Provisionally Certified Intellectual and Developmental Disabilities Therapist or a DMH Certified or Provisionally Certified Addiction Therapist (when appropriate for the individual receiving service and the service provided).

Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

Rule 1.16 Mental Illness Management Services

A. Mental Illness Management Services are covered by the Division of Medicaid for dates of service through June 30, 2012. As of July 1, 2012, Mental Illness Management Services as defined in this rule will no longer be covered by Medicaid. Mental health services for individuals having more complex mental health needs will be covered as Assertive Community Treatment, Community Support Services or other therapy services, as appropriate based on the individual need.

B. Mental Illness Management Services (MIMS) are intensive case management services with a therapeutic focus. Activities may include symptom evaluation/monitoring, crisis intervention, provision/enhancement of environmental supports, and other services directed towards helping the beneficiary live successfully in the community. MIMS are distinguished from traditional case management services by the higher level of professional expertise/skill of the provider, required by the more complex mental health needs of the beneficiary, of these services. MIMS may be provided in any appropriate community setting. MIMS may be provided to SED and MR/DD children or SPMI and MR/DD adults.

C. All services under this category must be provided by a staff member who holds a master's degree and professional license (ex:, Physician, Psychologist, Licensed Certified Social Worker, Licensed Master Social Worker, Licensed Professional Counselor or Licensed Marriage & Family Therapist) or who is a DMH Certified or Provisionally Certified Mental Health Therapist, DMH Certified or Provisionally Certified Intellectual and Developmental

Disabilities Therapist or a DMH Certified or Provisionally Certified Addiction Therapist (when appropriate for the individual receiving service and the service provided).

Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

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

Rule 2.1: Purpose

A. Its purpose is to provide home and community-based services to youth with serious emotional disturbance (SED).

B. Youth with SED are eligible to participate in the MYPAC program if they are at immediate risk of requiring treatment in a Psychiatric Residential Treatment Facility (PRTF) or if they are already in a PRTF and are ready to transition back to the community.

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

Rule 2.2: Eligibility

A. Applicants must meet clinical, financial, and age criteria to participate in the MYPAC program.

1. Clinical criteria: The Utilization Management and Quality Improvement Organization (UM/QIO) for the Division of Medicaid determines clinical eligibility and the appropriateness of the proposed delivery of services to program participants. The UM/QIO reviews and prior authorizes the provision of services.

    a) The youth 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 DSM on Axis I;

    b) The youth has 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) A youth meets the same level of care (LOC) for admission to a Psychiatric Residential Treatment Facility (PRTF), but can be diverted to MYPAC as an alternative to residential treatment.

    d) A youth is currently a resident of a PRTF or acute care facility, who continues to meet the LOC for residential treatment, but the can be transitioned back into the community with MYPAC services.

2. Financial criteria: The Division of Medicaid eligibility offices must determine an applicant's financial eligibility for the program.

3. Age: The youth must be admitted prior to his/her twenty-first (21st) birthday. If a youth is already a participant prior to age twenty-one (21), he/she may remain in MYPAC until treatment is completed or the participant's twenty-second (22nd) birthday, whichever occurs first.

B. An annual re-evaluation is required in order for a participant to be eligible to continue receiving services through MYPAC.

1. The re-evaluation recommendation must be made by the MYPAC treatment team psychiatrist or licensed psychologist, and must take into account the participant/family progress toward goals and the results of the Child and Adolescent Needs and Strengths – Mental Health (CANS-MH).

2. The re-evaluation is used for LOC determination and also guides and informs treatment.

C. When a participant is found clinically ineligible, the family will receive a Notice of Action advising them of the status of clinical eligibility and their appeal rights, including the right to a fair hearing. Refer to Part 300, Chapter 1.

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

Rule 2.3: Provider Participation Requirements

A. MYPAC services must be provided by mental health providers who meet the Mississippi Department of Mental Health (DMH) certification requirements and have a current Medicaid provider number. Each provider must conduct internal Quality Assurance activities to regularly review each participant's Individualized Service Plan (ISP) and treatment outcomes.

B. MYPAC Providers must meet the following requirements:

1. Hold certification by DMH to provide case management services,

2. Have a psychiatrist on staff,

3. Have appropriate clinical staff to provide therapy services needed,

4. Inform DOM in writing of any critical incidents (life-threatening, allegations of staff misconduct, abuse/neglect) and describes staff management of the incident,

5. Inform the participant/family of grievance and appeals procedures,

6. Report all grievances and appeals to the Division of Medicaid,

7. Has staff who meet the Division of Medicaid qualifications for the category of service they provide;

8. Be a qualified provider of wraparound facilitation,

9. Must have procedures in place for twenty-four (24) hours seven (7) days a week availability and response, and

10. Providers must 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. § 43-13-121; 43-13-117; 43-13-118; 43-13-129; 42 CFR 441, Subpart D; 42 CFR 441.151(a)(2)

Rule 2.4: MYPAC Service Requirements

A. MYPAC providers are required to provide, or arrange for the provision of, the following services:

1. Intensive Case Management, 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. It includes service coordination that involves finding and organizing multiple treatment and support services.

2. Wraparound Facilitation is 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 youth with complex mental health challenges and their families. The child and family team will meet regularly to monitor and adjust the plan of care if necessary or progress is not being made. Wraparound facilitation is intended to serve individuals who have serious mental health challenges that exceed the resources of a single agency or service provider, experienced multiple acute hospital stays, at risk of out-of-home placement or have been recommended for residential care or 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.

   Wraparound facilitation must be provided in accordance with high fidelity and quality wraparound practice.

   a) Services are comprised of a variety of specific tasks and activities designed to carry out the wraparound process, including:

1) Engaging the family,

2) Assembling the child and family team,

3) Facilitating a child and family team meeting at minimum every thirty (30) days,

4) Facilitating the creation of an ISP, this includes a plan for anticipating, preventing and managing crisis, within the child and family team meeting,

5) Working with the team in identifying providers of services and other community resources to meet family and youth needs,

6) Making necessary referrals for youth,

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

8) Presenting ISP for approval,

9) Providing copies of the ISP to the entire team including the youth and family/guardian,

10) Monitoring the implementation of the ISP and revising if 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 team to discuss and ensure the supports and services the youth and family are receiving continue to meet the caregiver and youth's needs,

14) Educating new team members about the wraparound process, and

15) Maintaining team cohesiveness.

b) Child and family team membership must include:

1) The wraparound facilitator,

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

3) The caregiver/guardian,

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

5) Identified youth, if age nine (9) or above, unless there are clear clinical indications this would be detrimental. Such reasons must be documented clearly throughout the record.

c) Respite care is defined by the Division of Medicaid as a planned break for families wherein, other responsible adults or trained counselors assume the duties of caregiving to allow the parent/caregivers a break. The two (2) types of respite care are:

1) In-home, or home and community-based, respite care is defined by DOM as short-term services provided to MYPAC participants who are unable to care for themselves and, because of the absence or need for relief of those persons who normally provide care for the participant.

2) Out-of-home or institutional respite care is defined by DOM as direct clinical services provided to MYPAC participants.

c) Services are medically oriented and include twenty-four (24) hour nursing supervision.

d) As a facility-based respite service, inpatient psychiatric hospitalization must be used for short-term treatment and crisis stabilization.

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

1. Psychiatrist:

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

b) 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.

1) Prescribing medication(s) to treat SED,

2) Educating the wraparound 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 with monitoring 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 supervise the utilization of any licensed/certified Psychiatric Mental Health Nurse Practitioner (PMHNP) who assists with responsibilities.

d) Must meet face-to-face or by telepsychiatry with the participant and family at least annually.

2. Master's level mental health therapists providing psychotherapy. Psychotherapy is defined as the intentional, face-to-face interaction between a mental health professional and a client in which a therapeutic relationship is established to help resolve symptoms of the individual's mental and/or emotional disturbance. For youth participating in MYPAC, this may include family therapy, group therapy, and individual therapy.

   a) Family Therapy is defined as psychotherapy that takes place between a mental health therapist and a youth's family members or guardians, with or without the presence of the youth. If a youth is in the custody of the Department of Human Services (DHS), family therapy may also include others, like DHS representatives or foster family members, acting in loco parentis. It is used to promote psychological and behavioral changes within families and usually meets on a regular basis.

   b) Group Therapy is defined as psychotherapy that takes place between a mental health therapist and at least two (2), but no more than eight (8), youth at the same time. If a group is co-led by two (2) mental health therapists, up to twelve (12) youth may participate at the same time. It is used to promote psychological and behavioral change and groups typically meet together on a regular basis. Possibilities include, but are not limited to, groups which focus on relaxation training, anger management and/or conflict resolution, social skills training, and self-esteem enhancement.

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

3. Wraparound Facilitators

   a) Wraparound facilitators and supervisors of the process must have completed Introduction to Wraparound 3-day training.

   b) Wraparound facilitators and supervisors must participate in ongoing coaching and training as defined by the Division of Medicaid.

   c) The provider organization providing Wraparound facilitation must be participating in the wraparound certification process through the Division of Medicaid or its designee.

d) Providers must ensure case load size for wraparound facilitators is maintained at an average of not more than ten (10) cases per wraparound facilitator.

4. Primary Services Coordinators (PSC).

a) One (1) MYPAC provider staff is identified as a PSC for each participant and family and ensures that appropriate case management services are identified and accessed.

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

c) Facilitates the wraparound team meetings and assures that all team members have the opportunity to participate.

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

e) Ensures needed resources are put 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 a crisis, and how a crisis may be defined differently by each family.

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

h) Available at all times, twenty-four (24) hours a day, to a participant and family for assistance.

C. Staff providing services to participants and families must receive a minimum of four (4) hours of clinical supervision, per month, which are provided through a combination of individual supervision, group supervision, peer consultation and participation in wraparound meetings. Documentation must clearly identify the supervision component.

D. The following services must be provided, but not limited:

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 MS Medicaid Cool Kids Program, or 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.

6. Other supports and services as identified by the family and wraparound team.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 441, Subpart D; 43-13-117(46); 43-14-1; 42 CFR 441.151(a)(2); Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

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. It is the plan that directs the treatment of the Medicaid MYPAC beneficiary.

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

1. The ISP must include the following:

a) Services which will be provided,

b) Frequency of service provision,

c) Who provides each service and their qualifications,

d) Both formal and informal supports which are available to the participant and family, and

e) Plans for anticipating, preventing and managing crises.

2. Every ISP must include an ICMP which:

a) Is developed during the wraparound meeting based on the individualized preferences of the participant and family.

b) Identifies triggers that may lead to potential crisis, or risk, and interventions, 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) Identify specific needs of families and tailor the level of intervention.

e) Provides responses that are readily accessible at any time to the participant 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) A copy of the ISP, along with a copy of the ICMP and contacts, must be provided to the participant and family.

3. The PSC monitors the ISP continuously through face-to-face visits with the participant and family.

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

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

c) A licensed clinical staff member is responsible for attending the wraparound team meeting at ninety (90) days and for submitting the updated ISP to the psychiatrist for review following the meeting.

d) The full wraparound team must participate in the development of the initial ISP, the annual ISP review and the discharge ISP, which includes at a minimum the psychiatrist, a licensed clinical staff member, the PSC, the participant and family.

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

Rule 2.6: Clinical Documentation Requirements

A. Participant records must be complete, accurate, accessible and organized. Clinical documents must include begin time and end time for each contact. Records must be maintained for a period of five (5) years. Refer to Maintenance of Records Part 200, Ch.1, Rule 1.3.

B. Records must contain the following categories:

1. Administrative Documentation:

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 participant, when the responsible party is anyone other than the participant's legal parent(s),

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

e) If the participant is in the custody of DHS, the county of custody should be specified and the caseworker identified as an agent of DHS, and

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

1) Participant rights and responsibilities,

2) Consent for treatment,

3) Complaints and grievances procedures, and

4) Appeals and right to fair hearing.

2. Assessments:

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 child's family,

4) Medical history,

5) Current educational functioning,

6) Family and participant strengths and needs, and

7) CANS-MH.

3. Treatment Planning must include:

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

b) ICMP, which should be included in the ISP,

c) Documentation must reflect Treatment Planning is occurring in the wraparound team meetings, and

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

4. Services provided, including:

a) Case Management progress notes which document:

1) Face-to-face meetings are conducted with the required frequency identified in the ISP,

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

3) Detailed narration from face-to-face meetings with participant and/or family, or collateral contacts (ex: setting, crisis, barriers, successes, etc.), and

4) Date and signature of PSC.

b) Wraparound 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) Respite services, if used, which document:

1) Reason, location and dates, and

2) Admission notes and other relevant documentation from the PRTF or psychiatric acute care facility, if out-of-home, facility-based or institutional, respite care was used.

d) Medication management documentation must include:

1) Medication(s) are being prescribed, reviewed, revised and monitored by the MYPAC psychiatrist at least every ninety (90) days. If the family chooses a different physician to prescribe medications, the MYPAC psychiatrist, as Medical Director, must still be involved in the wraparound process.

2) Medications have been accurately administered by the family in accordance with the physician or PMHNP‟s orders.

3) Informed consent for medication(s) is signed by the parent/guardian and participant, if age appropriate, that identifies the symptoms for which the medications are targeted, and evidence that education has been provided.

4) Effectiveness of medications.

5) Current medications as reflected in the Medication Profile Sheet.

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

7) Assessment for side effects, including physiological testing or other evaluations necessary, to monitor for adverse reactions or other health related issues that might arise from taking psychotropic medications.

8) Regular monitoring of medication(s) by the MYPAC provider and reporting any inconsistencies to the MYPAC psychiatrist.

e) Psychotherapy notes that contain the following elements:

1) Date of session,

2) Time session began and time session ended,

3) Types of therapy, either individual, family or group,

4) Person(s) participating in session,

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

6) Content of the session,

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

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

9) Outcome of the session,

10) Statement summarizing the participant 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; but note, monthly summaries are not acceptable in lieu of psychotherapy session notes.

5. Discharge planning, including:

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

b) Documentation must reflect discharge planning is done with the participant and family through the wraparound process.

c) At the time of the MYPAC participant's discharge, the record must contain a signed copy of the final discharge plan with signatures of the MYPAC participant and caregiver/guardian.

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

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 who is enrolled in MYPAC is admitted to a psychiatric acute care facility (PRTF) for respite, 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; 42 CFR 483, Subpart G

Rule 2.8: Discharge/Transition Planning

A. For all participants in the MYPAC program, discharge planning begins at admission and the MYPAC provider is responsible for assisting the family with transition plans through the wraparound process. Successful transition builds upon gains that have been made and can be achieved by linking the participant and family to resources and services. That supports their recovery process, manage their illness, and help them live meaningful lives in their communities. The Primary Service Coordinator (PSC) who facilitates the participant's wraparound team must access and link appropriate services to the participant and family prior to disenrollment.

B. Discharge from the MYPAC program occurs in several ways, including:

1. "Aging out," or when the participant reaches twenty-two (22) years of age,

2. Participant and family use their freedom of choice to end MYPAC services,

3. Participant and family moves out of state,

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

5. Out-of-home, or institutional, respite limits are exceeded and continued PRTF placement is required.

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

1. MYPAC begin and end date,

2. Reason for discharge,

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

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

5. A list of the youth's diagnoses,

6. Detailed information about the youth's medications: the names, strengths and dosage instructions in lay language for all medications prescribed for the participant, as well as any special instructions such as lab work requirements,

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

    a) Where follow-up mental health services will be obtained with contact name, address and phone number.

    b) Where the child will attend school, with name and contact information of identified educational staff.

    c) Other recommended resources, including recreational, rehabilitative, or other special programs believed to offer benefit to the participant and family, that includes the corresponding contact information for those resources or services.

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

8. Detailed and specific recommendations in writing that will transfer knowledge gained from the youth'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 youth.

D. At the time of the participant's discharge from MYPAC, the provider must supply the parent/guardian with:

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

2. A written prescription for a thirty (30) day supply of all medications prescribed for the participant, if the current supply does not exceed thirty (30) days.

E. The provider must obtain signed consent from the participant 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. § 43-13-121; 42 CFR 441, Subpart D; 43-13-117(46); 43-14-1

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 all grievances by participants and/or family members, or third-parties on behalf of participants. MYPAC Providers must submit to the Division of Medicaid a quarterly report summarizing each grievance, either on-going or resolved, that was forwarded during the quarter.

B. The Division of Medicaid defines an appeal as a formal request to change a decision. A fair hearing process is initiated when a participant/family disagree with an adverse decision following an appeal to the MYPAC provider.

1. If a participant and/or family request a fair hearing by the Division of Medicaid, after formally appealing an adverse decision by the MYPAC provider, the MYPAC providers must:

a) Maintain records of any appeals including those received by subcontractors,

b) Establish an appeal and fair hearing process that includes written policies and procedures, and

c) Participate in any review, appeal, fair hearing or litigation involving issues related to MYPAC at the request of the Division of Medicaid.

2. The MYPAC provider must:

a) Forward the request to the Division of Medicaid within two (2) business days of receipt,

b) Include the Notice of Action that was provided to the participant/family within ten (10) days before the date of any action by the MYPAC provider to terminate, suspend or reduce services, and

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

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

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 participant. MYPAC providers must have written policies for documenting and reporting all critical incidents/occurrences. Documentation regarding critical incidents must reflect the following:

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

2. Report to appropriate authorities 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 participants and providers,

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

5. Runaway of a participant.

Source: Miss. Code Ann. § 43-13-1