

Title 23: Division of Medicaid

Part 206: Mental Health Services

Part 206 Chapter 1: Community Mental Health Services

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. The supervisor must be of the same discipline as those they supervise.
 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 at a minimum, one of the following: 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: Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised 09/1/2020; Revised eff. 04/17/2020.

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 than 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

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: Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 09/1/2020; Revised eff. 04/17/20.

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. The supervisor must be of the same discipline as those they supervise.

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 - The case record must contain a monthly progress summary for each beneficiary that includes:
 - a) Notation of each date the service was provided,
 - b) The length of time the service was provided on each date, and
 - c) A summary of the beneficiary's progress that relates to the goals and objectives established on the Treatment Plan.

B. Reserved.

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. The supervisor must be of the same discipline as those they supervise.
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 - The case record must contain a progress summary for each beneficiary that includes:
 - a) Notation of each date the service was provided,
 - b) The length of time the service was provided on each date, and
 - c) 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: Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 09/1/2020; Revised eff. 04/17/20.

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

Rule 2.2: Eligibility

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

1. The Utilization Management and Quality Improvement Organization (UM/QIO) for the Division of Medicaid reviews and prior authorizes the provision of services based on all the following clinical criteria. A beneficiary:
 - a) Must be diagnosed by a psychiatrist or licensed psychologist with a mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria for Serious Emotional Disturbance (SED) specified within the Diagnostic and Statistical Manual (DSM) and must be cognitively able to actively participate in the services recommended by the Individual Service Plan, or
 - b) Is currently a resident of a PRTF or acute care facility who continues to meet the LOC for residential treatment but can be transitioned into the community with MYPAC services or meets the same level of care (LOC) for admission to a PRTF but can be diverted to MYPAC as an alternative to residential treatment.
2. A beneficiary must be admitted prior to his/her twenty-first (21st) birthday; however, if a beneficiary is already receiving MYPAC services prior to age twenty-one (21), he/she may remain in MYPAC until treatment is completed or the beneficiary's twenty-second (22nd) birthday, whichever occurs first.

B. MYPAC services are provided to eligible beneficiaries under the State Plan Rehabilitation Option Intensive Outpatient Psychiatric Services.

Source: OBRA Section 455; 42 USC 1396a; 42 CFR §§ 441, Subpart D, 483.352; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 09/1/2020; Revised eff. 4/17/2020; Revised to correspond with SPA 2012-003 (eff. 07/01/2012) eff. 12/01/2013.

Rule 2.6: Clinical Documentation Requirements

- A. Beneficiary records must be complete, accurate, accessible and organized.
 1. Clinical documents must include begin time and end time for each contact.
 2. Records must be maintained for a period of five (5) years after the beneficiary reaches the age of twenty-one (21).
 3. Refer to Maintenance of Records Part 200, Chapter 1, Rule 1.3.
- B. Records must contain the following categories:
 1. Administrative Documentation must include:
 - a) Demographic information that includes date of birth, gender, and race,

- b) Copy of the participant's birth certificate and/or social security card,
- c) Copy of any legal documents verifying custody or guardianship of the beneficiary, when the responsible party is anyone other than the beneficiary's legal parent(s),
- d) Name, address and phone number of the party bearing legal responsibility for the beneficiary should be clearly identified, along with his/her relationship to the beneficiary,
- e) Assigned county of custody and the caseworker identified as an agent of DHS if the beneficiary is in the custody of DHS, and
- f) Documents signed and dated by the beneficiary and/or family that inform them of:
 - 1) Beneficiary's rights and responsibilities,
 - 2) Consent for treatment,
 - 3) Complaints and grievances procedures, and
 - 4) Appeals and right to fair hearing.

2. Assessments must include:

- a) Psychiatric diagnostic evaluation or psychological diagnostic testing evaluation which must include documentation of the need for MYPAC level of care.
 - 1) If no evaluation has been conducted within the last twelve (12) months, one must be completed within sixty (60) days prior to admission,
 - 2) If an evaluation has been conducted within the last twelve (12) months, an update addendum must be completed within the fourteen (14) days following MYPAC admission.
- b) Bio-psychosocial assessment that includes:
 - 1) Developmental profile,
 - 2) Behavioral assessment,
 - 3) Assessment of the potential resources of the beneficiary's family,
 - 4) Medical history,
 - 5) Current educational functioning, and

- 6) Family and beneficiary strengths and needs
3. Treatment Planning must include:
 - a) ISP signed and dated by the child and family team and in place within fourteen (14) days of enrollment in MYPAC, and reviewed with wraparound team every thirty (30) days,
 - b) ICMP included in the ISP,
 - c) Documentation treatment planning is occurring in the child and family team meetings, and
 - d) Treatment Planning is directed by the MYPAC beneficiary and family.
 4. Services provided must include:
 - a) Wraparound facilitation progress notes which document:
 - 1) The relationship of services to identified needs of family and beneficiary as stated in the ISP,
 - 2) Detailed narration from face-to-face meetings with the beneficiary and/or family, or collateral contacts, including setting, crisis, barriers and successes, and
 - 3) Date and signature of wraparound facilitator.
 - b) Child and family team meeting notes which document:
 - 1) The purpose and results of services provided that are consistent with the needs outlined in the ISP,
 - 2) Changes to ISP, including dates and reason for changes,
 - 3) Treatment successes,
 - 4) Implementation of the ICMP and outcome, if used,
 - 5) Names and positions or roles of each team member, and
 - 6) Dates and signatures of participating team members.
 - c) Medication management and monitoring documentation must include:

- 1) Evidence the treating psychiatrist has managed all beneficiary SED medication(s) at least every ninety (90) days, including but not limited to, reviewing, revising, adjusting, discontinuing and monitoring.
 - 2) If the family chooses a different physician to prescribe medication(s) used in the treatment of the beneficiary's SED, the psychiatrist employed by the MYPAC provider as Medical Director must provide feedback on the implementation of the ISP.
 - 3) Medication(s) to treat the beneficiary's SED are accurately administered by the family in accordance with the physician or PMHNP's orders.
 - 4) Informed consent for medication(s) used in the management of the beneficiary's SED is signed by the parent/guardian and beneficiary, if age appropriate, identifying the symptoms the medications target and evidence education has been provided.
 - 5) Effectiveness of medication(s) to treat the beneficiary's SED.
 - 6) Current medication(s) to treat the beneficiary's SED as reflected in the medication profile sheet.
 - 7) Assistance to family with obtaining, administering and monitoring any medication(s) prescribed for the treatment of the beneficiary's SED.
 - 8) Assessment for side effects of medication(s) to treat beneficiary's SED including physiological testing or other evaluations necessary to monitor for adverse reactions or other health related issues that might arise from taking medication(s) to treat beneficiary's SED.
 - 9) Regular monitoring of medication(s) to treat the beneficiary's SED by the MYPAC provider and reporting any inconsistencies to the treating psychiatrist.
- d) Psychotherapy notes must include:
- 1) Date of session,
 - 2) Time session began and time session ended,
 - 3) Specify if therapy is individual, family or group,
 - 4) Person(s) participating in session,
 - 5) Clinical observations about the beneficiary and/or family, including demeanor, mood, affect, mental alertness, and thought processes,

- 6) Content of the session,
 - 7) Therapeutic interventions attempted and beneficiary/family's response to the intervention,
 - 8) Beneficiary's response to any significant others who may be present in the session,
 - 9) Outcome of the session,
 - 10) Statement summarizing the beneficiary and/or family's degree of progress toward the treatment goals,
 - 11) Signature, credentials and printed name of therapist, and
 - 12) Notes for each session. Monthly summaries are not acceptable in lieu of psychotherapy session notes.
5. Discharge planning documentation must include:
- a) Discharge planning began the first (1st) day of admission.
 - b) Discharge planning is done with the beneficiary and family through the wraparound process.
 - c) A signed copy of the final discharge plan with signatures of the MYPAC beneficiary and caregiver/guardian at the time of discharge.

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

History: Revised eff. 09/01/2020; Revised to correspond with SPA 2012-003 (eff. 07/01/2012) eff. 12/01/2013.