Title 23: Division of Medicaid

Part 223: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services

Chapter 6: Expanded Rehabilitative Services

Rule 6.6: Documentation

A. The medical record must be in compliance with Miss. Admin. Code Part 200, Rule 1.3 and include the following documentation:

1. Consent for treatment obtained yearly,
2. Date of service,
3. Type of service provided,
4. Time session began and time session ended,
5. Length of time spent delivering the service,
6. Identification of individual(s) receiving or participating in the service,
7. Summary of what transpired in the session,
8. Treatment Plan reviewed and revised as needed every six (6) months or as medically indicated,
9. Evidence that the session relates to the goals and objectives established in the treatment plan,
10. Name, title, and signature of the servicing provider providing the service,
11. Name, title, and signature of the individual who documented the services.
12. All documentation must be legible, easily read and clearly understood.

B. A treatment plan must include, at a minimum:

1. A dimensional approach non-axial diagnosis with separate notations for important psychosocial, contextual factors, and disability,
2. Identification of the beneficiary's and/or family's strengths,
3. Identification of the clinical problems, or areas of need,

4. Treatment goals for each identified problem,

5. Treatment objectives that represent incremental progress towards goals with target dates for achievement,

6. Specific treatment modalities and/or strategies employed to meet each objective,

7. Date of implementation of the treatment plan and signatures of the provider, beneficiary, and parent/guardian.

8. Signatures from the provider and beneficiary to verify the date of review and/or revision to treatment plan.

9. Signatures obtained from each of the appropriate practitioners acknowledging the service that each will provide for the beneficiary.

C. MYPAC Service records must contain the following:

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 clearly identified with their relationship to the beneficiary,

e) Assigned county of custody and the caseworker identified as an agent of the Department of Child Protective Services (CPS) if the beneficiary is in the custody of CPS, 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. Assessment documentation must include:

a) Psychiatric diagnostic evaluation or psychological diagnostic testing evaluation which documents the need for Mississippi Youth Program Around the Clock (MYPAC) level of care (LOC).

1) The original and evaluation and addendum must be stored in the medical record with any addendums.

2) An evaluation must be completed within sixty (60) days prior to admission if no evaluation has been conducted within the last twelve (12) months.

3) An updated addendum must be completed within the fourteen (14) days following MYPAC admission if an evaluation has been conducted within the last twelve (12) months.

b) Psychosocial assessment that includes:

1) Medical history,

2) Developmental profile,

3) Behavioral assessment,

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

5) Current educational functioning, and

6) Family and beneficiary strengths and needs

3. Wraparound Service Plan (WSP) documentation must include:

a) WSP 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) Individualized Crisis Management Program (ICMP) included in the WSP,

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. Documentation of 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 WSP,

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 WSP,

2) Changes to WSP, 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) Current medication(s) to treat the beneficiary's SED as reflected in the medication profile sheet.

2) Evidence the treating psychiatrist, physician, physician assistant (PA) or psychiatric mental health nurse practitioner (PMHNP) are managing all beneficiary SED medication(s) at least every ninety (90) days, including but not limited to, reviewing, revising, adjusting, discontinuing and monitoring.

3) Feedback on the implementation of the WSP from the psychiatrist employed by the MYPAC provider as Medical Director if the family chooses a different physician to prescribe medication(s) used in the treatment of the beneficiary's SED,

4) Administration of medication(s) to treat the beneficiary's SED is accurately performed by the family in accordance with the physician or PMHNP's orders.

5) 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, side effects and evidence of education.

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

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, physician, PA or PMHNP.

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 beneficiary and caregiver/guardian at the time of discharge.

6. At the time of the beneficiary's discharge from MYPAC services, the discharge/transition plan must be amended to include any of the following, if applicable:

a) MYPAC services begin and end date,

b) Reason for discharge,

c) The name of the person or agency that cares for and has custody of the beneficiary,

d) The physical location/address where the beneficiary resides,

e) A list of the beneficiary's diagnoses,

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

7. 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.

d) A thirty (30) day prescription for each of the beneficiary's medications.

e) Signed consent from the beneficiary and family to provide copies of the final discharge plan to the providers of follow-up mental health, education and other services to be provided after discharge.

D. Documentation of services must comply with the Department of Mental Health's Record Guide and any supplemental instructions provided by DMH in effect at the time the service is provided.

Source: 42 C.F.R. §§ 440.130, 441.57; Miss. Code Ann. §§ 43-13-117, 43-13-121; SPA 20-0022.

History: Revised eff. 01/01/2021. New rule (to correspond with SPA 20-0022 eff. 09/01/2020) eff. 11/01/2020.