Title 23: Division of Medicaid

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

Chapter 1: General

Rule 1.3: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Provider Participation Requirements

A. Enrolled Mississippi Medicaid providers who have signed an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) specific provider agreement must conduct periodic screenings and medically necessary interperiodic visits for all EPSDT-eligible beneficiaries in accordance with the EPSDT Periodicity Schedule as recommended by the American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule and must provide or refer EPSDT-eligible beneficiaries with an identified need for additional assessment, diagnosis, and/or treatment services to an appropriate provider.

B. Dental providers must provide services to all EPSDT-eligible beneficiaries in accordance with the dental schedule of the American Academy of Pediatric Dentistry (AAPD) and in accordance with AAP guidelines. Dental providers must provide or refer EPSDT-eligible beneficiaries with an identified need for additional assessment, diagnosis, and/or treatment services to an appropriate provider.

C. EPSDT screening providers must refer EPSDT-eligible beneficiaries to other enrolled Mississippi Medicaid licensed practitioners of the beneficiary's choice for assessment, diagnosis and/or treatment services necessary to correct or ameliorate any physical, mental, psychosocial and/or behavioral health conditions discovered by the screenings, whether or not such services are covered under the State Plan.

D. Off-site Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening providers must submit the following information to the Division of Medicaid:

    1. A completed and signed secondary location form documenting the off-site provider's ability to complete all age-appropriate components of EPSDT screenings;

    2. An attestation that the EPSDT screenings will be completed by an approved EPSDT screening provider who has completed the Division of Medicaid's EPSDT provider agreement and that all required equipment and supplies are available at the off-site location.

    3. A signed agreement between the off-site location authority including, but not limited to, a school superintendent, principal, day care director, and the screening provider.

    4. A list of all physical addresses of the off-site locations where the EPSDT screenings will be provided and a monthly schedule for each location designating the dates and times the EPSDT screenings will be offered.

5. Information packet materials including, but not limited to, letters, consent forms, and examples of anticipatory guidance information sheets to be provided which must be prior approved by the Division of Medicaid.

6. A copy of the provider's Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or CLIA number, if applicable.

E. EPSDT screenings cannot begin at an off-site location until an approval has been authorized in writing by the Division of Medicaid.

Source: 42 U.S.C § 1396d; 42 C. F.R. Part 441, Subpart B; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 07/01/2021; Revised eff. 11/01/2020; Revised to correspond with SPA 2015-017 (eff. 11/01/2015), eff. 10/01/2016.

Rule 1.5: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Screenings

A. An initial or established age-appropriate medical screening which must include at a minimum:

1. A comprehensive health and developmental history including assessment of both physical and mental health development and family history,

2. A comprehensive unclothed physical examination,

3. Appropriate immunizations according to the Advisory Committee on Immunization Practices (ACIP), and specific to age and health history,

4. Laboratory tests adhering to the AAP Bright Futures Periodicity Schedule,

5. Sexual development and sexuality screening adhering to the AAP Bright Futures Periodicity Schedule, and

6. Health education, including anticipatory guidance.

B. Developmental screening or surveillance to include diagnosis with referral to an enrolled Mississippi Medicaid provider for diagnosis and treatment for defects discovered.

C. Psychosocial/behavioral assessment to include diagnosis with referral to an enrolled Mississippi Medicaid provider for diagnosis and treatment for defects discovered.

D. Vision screening, at a minimum, to include diagnosis with referral to an enrolled Mississippi Medicaid optometry or ophthalmology provider for diagnosis and treatment for defects discovered.

E. Hearing screening, at a minimum, to include diagnosis with referral to an enrolled Mississippi Medicaid audiologist, otologist, otolaryngologist or other physician hearing specialists for diagnosis and treatment for defects discovered.

F. Dental screening, at a minimum, to include diagnosis with referral to an enrolled Mississippi Medicaid dental provider for beneficiaries at eruption of the first tooth or twelve (12) months of age for diagnosis and referral to a dentist for treatment and relief of pain and infections, restoration of teeth and maintenance of dental health.

G. Maternal depression screening, to include a referral:

1. To an enrolled Medicaid provider if the mother is eligible for Medicaid, or

2. To other healthcare providers as medically indicated including, but not limited to:

a) Federally Qualified Health Center (FQHC),

b) Rural Health Clinic (RHC), or

c) Community Mental Health Center (CMHC).

H. The Division of Medicaid covers off-site screening at the following locations:

1. School,

2. Daycare center, or

3. Head start center.

I. Off-site Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screening providers must:

1. Provide off-site screenings only within the county or within forty (40) miles of the county where the physician's office is located,

2. Develop and adhere to confidentiality policies that are approved by the Division of Medicaid.

3. Ensure medical personnel performing the physical examination are limited to Mississippi Medicaid enrolled physicians, nurse practitioners or a physician assistants employed by the physician's office.

4. Complete all age-appropriate components of the EPSDT screening during one (1) visit or encounter.

5. Have a designated well-lit private room to perform the screening assessments which must

be in close proximity to:

a) Hot and cold running water, and

b) A bathroom.

6. Obtain written parental/guardian consent:

a) The written consent must contain the following statements:

1) Parent/guardian right to be present during EPSDT screenings,

2) The physical examination will be unclothed,

3) The EPSDT screenings take the place of the yearly wellness exam performed at the beneficiary's primary care provider's office, and

4) Vaccines will be administered, if applicable,

b) Must include a space for the parent/guardian signature and date giving approval for the EPSDT screenings to be performed, and

c) Must be received within sixty (60) days prior to the EPSDT screenings.

7. Encourage the parent/guardian to be present during the EPSDT screenings,

8. Follow-up with the parent/guardian on the results of the screening by mail or in a one-on-one meeting.

9. Utilize the anticipatory guidance materials that are:

a) Age appropriate,

b) Mailed to the parent/guardian for beneficiaries under the age of fourteen (14).

c) Given to beneficiaries fourteen (14) years of age and above.

J. The Division of Medicaid does not reimburse for services other than EPSDT screenings in an off-site location.

Source: 42 U.S.C. §1396d; 42 C.F.R Part 441, Subpart B; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 07/01/2021; Revised eff. 11/01/2020; Revised to correspond with SPA 18-0014 (eff. 10/01/2018) effective 12/1/2018. Revised to correspond with SPA 15-017 (eff. 11/01/2015), eff. 10/01/2016.

Rule 1.8: Reimbursement

A. The Division of Medicaid reimburses a separate fee in addition to the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) periodic screenings and medically necessary interperiodic visits for each of the following when documented in accordance with Miss. Admin. Code Title 23, Part 223, Rule 1.6.A.

   1. Developmental screenings according to the American Academy of Pediatrics (AAP) guidelines,

   2. Vision screenings,

   3. Hearing screenings,

   4. Autism screenings,

   5. Depression screenings,

   6. Maternal depression screening, and

   7. Other medically necessary services prior authorized by the Division of Medicaid or designee, if required:

      a) Lab tests, excluding hemoglobin or hematocrit,

      b) Diagnostic tests, and

      c) Other procedures.

B. The Division of Medicaid reimburses EPSDT screening fees using Current Procedural Terminology (CPT) Codes based on the American Medical Association (AMA) methodology for determining medical services at the same rate that was in effect for State Fiscal Year (SFY) 2021.

C. The Division of Medicaid only reimburses Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC) and Mississippi Department of Health (MSDH) Clinics an encounter rate that is all inclusive of all items listed in Miss. Admin. Code Title 23, Part 223, Rule 1.8.A.

Source: 42 U.S.C. § 1396d; 42 C.F.R Part 441, Subpart B; Miss. Code Ann. §§ 43-13-117, 43-13-121.

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Chapter 2: Early Intervention / Targeted Case Management

Rule 2.5: Reimbursement

A. The Division of Medicaid uses rate setting as a prospective method of reimbursement on both the state and federal level. This method does not allow for retrospective settlements. The rates are determined from cost reports and appropriate audits.

B. Standard rates will remain the same as those in effect for State Fiscal Year (SFY) 2021. The Division of Medicaid uses a fee-for-service reimbursement rate which will remain the same as those in effect for State Fiscal Year (SFY) 2021. In no case may the reimbursement rate for services provided exceed an individual facility's customary charge to the public for such services in the aggregate, except for those public facilities rendering such services free of charge or at a nominal charge.

C. Payments under the plan do not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

D. Case management providers are paid on a unit of service basis that does not exceed fifteen (15) minutes.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(19)(b); 34 CFR 303

History: Revised eff. 07/01/2021.

Chapter 6: Expanded Rehabilitative Services

Rule 6.1: Definitions

A. The Division of Medicaid defines:

1. Clinical/medical case record as the central repository of all pertinent information about the beneficiary that provides an accurate chronological accounting of the treatment plan and progress.

2. Day treatment as a behavioral intervention and strengths-based program, provided in the context of a therapeutic milieu, which enables beneficiaries between the ages of three (3) and twenty-one (21) with serious emotional disturbances or autism/Asperger's syndrome to live in the community.

3. A developmental evaluation as an assessment by a licensed practitioner utilizing standardized developmental instruments of the current cognitive, social and motor function of beneficiaries younger than three (3) years of age or beneficiaries with such severe mental or physical disabilities that a standardized intellectual assessment is not possible.

4. Duplication of services as the provision of the same service to the same beneficiary by the same or different provider on the same day.

5. A neuropsychological evaluation as a performance-based method to assess cognitive functioning which includes the collection of diagnostic information, differential diagnostic information, assessment of treatment response, and prediction of functional potential and recovery potential.

6. Wraparound facilitation as a targeted case management program that includes the creation and facilitation of a child/youth and family team for the purpose of developing a single care plan to address the needs of children/youth with complex mental health challenges and their families.

B. Service definitions in Miss. Admin. Code Title 23, Part 206, Rule 1.3 are applicable to this Part.

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

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

Rule 6.2: Provider Requirements

A. Providers of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Rehabilitative Services must comply with the provider requirements described in Miss. Admin. Code Title 23, Part 206, Rule 1.1.

B. Providers employing any evidence-based practices (EBP) in the course of treatment must have completed the appropriate training for the specific EBP.

C. Wraparound facilitators must be certified by the Mississippi Department of Mental Health (DMH).

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

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

Rule 6.3: Covered Services

A. All State Plan services described in Miss. Admin. Code Part 206 and Part 223 are covered for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)-eligible beneficiaries without regard to service limits when prior authorized by the Utilization Management/Quality Improvement Organization (UM/QIO).

B. The Division of Medicaid covers neuropsychological evaluations for EPSDT-eligible beneficiaries when medically necessary, prior authorized by a UM/QIO, the Division of Medicaid or designee and conducted by a psychologist trained to administer, score and interpret neuropsychological instruments, and one (1) or more of the following apply:

1. Other interventions have been unsuccessful with the beneficiary,

2. Previous psychological evaluation indicates neuropsychological deficits and supports justification,

3. The beneficiary displays evidence of cognitive deficits or brain injury, or

4. Results are used in treatment planning and placement decisions.

C. The Division of Medicaid covers developmental evaluations for EPSDT-eligible beneficiaries when medically necessary, prior authorized by a UM/QIO, the Division of Medicaid or designee, conducted by a physician or a psychologist with knowledge and expertise to administer and interpret developmental evaluation results and uses the results or the following:

1. To assist in treatment planning for a beneficiary less than three (3) years of age or a beneficiary with a severe disability, or

2. To confirm the existence of a major diagnosis.

D. The Division of Medicaid covers day treatment services for EPSDT eligible beneficiaries when the service and provider meet the following requirements:

1. Service components include:

a) Treatment plan development and review.

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

2. Certified to operate by the Mississippi Department of Mental Health (DMH).

3. Included in a care plan approved by one (1) of the following: a psychiatrist, physician, psychologist, psychiatric mental health nurse practitioner (PMHNP), physician assistant (PA), licensed clinical social worker (LCSW), licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), licensed medical social worker (LMSW) or certified mental health therapist (CMHT).

4. Provided by a psychiatrist, physician, psychologist, PMHNP, PA, LCSW, LPC, LMFT, LMSW or CMHT.

5. Prior authorized as medically necessary by the UM/QIO.

E. The Division of Medicaid covers medically necessary wraparound facilitation as part of a targeted case management benefit for EPSDT-eligible beneficiaries with a serious emotional disturbance (SED) that meet the level of care provided in a psychiatric residential treatment facility (PRTF).

1. Service components include:

    a) Engaging the family,

    b) Assembling the beneficiary and family team which includes all of the required entities and individuals described in the DMH operational standards.

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

    d) Facilitating the development of a wraparound service plan (WSP) through decisions made by the beneficiary and family team during the beneficiary and family team meeting, including a plan for anticipating, preventing and managing crisis,

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

    f) Making necessary referrals for beneficiaries,

    g) Documenting and maintaining all information regarding the WSP, including revisions and beneficiary and family team meetings,

    h) Presenting WSP for approval to the beneficiary and family team,

    i) Providing copies of the WSP to the entire team including the beneficiary and family/guardian,

    j) Monitoring the implementation of the WSP and revising as necessary to achieve outcomes,

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

    l) Evaluating the progress toward needs being met to ensure the referral behaviors have decreased,

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

    n) Educating new team members about the wraparound process,

    o) Maintaining team cohesiveness,

    p) Meeting face-to-face with the beneficiary once a week,

    q) Meeting face-to-face with the family twice a month,

r) Meeting with other collateral contacts related to WSP implementation at least three (3) times a week, and

s) Ensuring medication and management and monitoring of beneficiaries on medication(s) used in the treatment of the beneficiary's Serious Emotional Disturbance (SED) occur at a physician visit every ninety (90) days at a minimum.

2. Wraparound services are provided by a Certified Wraparound Facilitator.

3. The ISP must be approved by one (1) of the following team members: a psychiatrist, physician, psychologist, PMHNP, PA, LCSW, LPC, or LMFT.

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

History: Revised eff. 07/01/2021; New rule (to correspond with SPA 20-0022 eff. 09/01/2020) eff. 11/01/2020.

Rule 6.4: Non-Covered Services

A. The Division of Medicaid does not cover:

1. Educational interventions of an academic nature performed by the Department of Education,

2. Same service provided on the same date, regardless of the setting(s) in which the service was provided unless service specifically states otherwise.

3. Community-based mental health services when a beneficiary is an inpatient of a Medicaid-covered facility,

4. Time spent on documentation, unless completed during the session and relevant to the treatment goals,

5. Time spent completing a care plan form or prior authorization request online via web portal,

6. Staff travel time,

7. Field trips and routine recreational activities,

8. Beneficiary travel time to and from any service, or

9. Services provided to more than one (1) beneficiary at a time, unless specifically allowed in the service definition.

B. The Division of Medicaid does not cover the following evaluative services:

1. A neuropsychological evaluation when:

    a) Only administered to rule out attention deficit hyperactivity disorder (ADHD), or

    b) Previous evaluations did not support the suspicion of cognitive deficits or brain injury.

2. The Division of Medicaid does not cover a developmental evaluation when:

    a) Referral questions can be adequately answered through behavioral observation and family interviews, or

    b) A standardized intellectual assessment is appropriate and the beneficiary is three (3) years or older with no severe disabilities.

Source: Miss. Code Ann. § 43-13-117.

History: Revised eff. 07/01/2021; New rule (to correspond with SPA 20-0022 eff. 09/01/2020) eff. 11/01/2020.

Rule 6.5: Reimbursement

A. The Division of Medicaid reimburses expanded rehabilitative services based on a statewide uniform fee schedule.

B. The Division of Medicaid does not reimburse for the duplication of services.

1. Providers are responsible for coordinating services with the beneficiary and guardian/legal representative to avoid service duplication when the beneficiary is receiving mental health services at more than one (1) location from more than one (1) provider.

2. When duplicate service claims are filed the provider billing the first claim is reimbursed.

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

History: Revised eff. 07/01/2021; New rule (to correspond with SPA 20-0022 eff. 09/01/2020) eff. 11/01/2020.

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. Documentation of services that are subject to certification by the Department of Mental Health (DMH) 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. 07/01/2021; Revised eff. 01/01/2021. New rule (to correspond with SPA 20-0022 eff. 09/01/2020) eff. 11/01/2020.

Title 23: Division of Medicaid

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

Chapter 1: General

Rule 1.3: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Provider Participation Requirements

A. Enrolled Mississippi Medicaid providers who have signed an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) specific provider agreement must conduct periodic screenings and medically necessary interperiodic visits for all EPSDT-eligible beneficiaries in accordance with the EPSDT Periodicity Schedule as recommended by the American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule and must provide or refer EPSDT-eligible beneficiaries with an identified need for additional assessment, diagnosis, and/or treatment services to an appropriate provider.

B. Dental providers must provide services to all EPSDT-eligible beneficiaries in accordance with the dental schedule of the American Academy of Pediatric Dentistry (AAPD) and in accordance with AAP guidelines. Dental providers must provide or refer EPSDT-eligible beneficiaries with an identified need for additional assessment, diagnosis, and/or treatment services to an appropriate provider.

C. EPSDT screening providers must refer EPSDT-eligible beneficiaries to other enrolled Mississippi Medicaid licensed practitioners of the beneficiary's choice for assessment, diagnosis and/or treatment services necessary to correct or ameliorate any physical, mental, psychosocial and/or behavioral health conditions discovered by the screenings, whether or not such services are covered under the State Plan.

D. Off-site Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening providers must submit the following information to the Division of Medicaid:

1. A completed and signed secondary location form documenting the off-site provider's ability to complete all ~~age appropriate~~age-appropriate components of EPSDT screenings;

2. An attestation that the EPSDT screenings will be completed by an approved EPSDT screening provider who has completed the Division of Medicaid's EPSDT provider agreement and that all required equipment and supplies are available at the off-site location.

3. A signed agreement between the off-site location authority including, but not limited to, a school superintendent, principal, day care director, and the screening provider.

4. A list of all physical addresses of the off-site locations where the EPSDT screenings will be provided and a monthly schedule for each location designating the dates and times the EPSDT screenings will be offered.

5. Information packet materials including, but not limited to, letters, consent forms, and examples of anticipatory guidance information sheets to be provided which must be prior approved by the Division of Medicaid.

6. A copy of the provider's Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or CLIA number, if applicable.

E. EPSDT screenings cannot begin at an off-site location until an approval has been authorized in writing by the Division of Medicaid.

Source: 42 U.S.C § 1396d; 42 C. F.R. Part 441, Subpart B; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 07/01/2021; Revised eff. 11/01/2020; Revised to correspond with SPA 2015-017 (eff. 11/01/2015), eff. 10/01/2016.

Rule 1.5: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Screenings

A. An initial or established ~~age appropriate~~age-appropriate medical screening which must include at a minimum:

1. A comprehensive health and developmental history including assessment of both physical and mental health development and family history,

2. A comprehensive unclothed physical examination,

3. Appropriate immunizations according to the Advisory Committee on Immunization Practices (ACIP), and specific to age and health history,

4. Laboratory tests adhering to the AAP Bright Futures Periodicity Schedule,

5. Sexual development and sexuality screening adhering to the AAP Bright Futures Periodicity Schedule, and

6. Health education, including anticipatory guidance.

B. Developmental screening or surveillance to include diagnosis with referral to an enrolled Mississippi Medicaid provider for diagnosis and treatment for defects discovered.

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F. Dental screening, at a minimum, to include diagnosis with referral to an enrolled Mississippi Medicaid dental provider for beneficiaries at eruption of the first tooth or twelve (12) months of age for diagnosis and referral to a dentist for treatment and relief of pain and infections, restoration of teeth and maintenance of dental health.

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1. To an enrolled Medicaid provider if the mother is eligible for Medicaid, or

2. To other healthcare providers as medically indicated including, but not limited to:

a) Federally Qualified Health Center (FQHC),

b) Rural Health Clinic (RHC), or

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H. The Division of Medicaid covers off-site screening at the following locations:

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2. Daycare center, or

3. Head start center.

I. Off-site Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screening providers must:

1. Provide off-site screenings only within the county or within forty (40) miles of the county where the physician's office~~, RHC or FQHC~~ is located,

2. Develop and adhere to confidentiality policies that are approved by the Division of Medicaid.

3. ~~Ensure medical~~Ensure medical personnel performing the physical examination are limited to Mississippi Medicaid enrolled physicians, nurse practitioners or a physician assistants employed by the physician's office~~, FQHC or RHC~~.

4. Complete all ~~age-appropriate~~age-appropriate components of the EPSDT screening during one (1) visit or encounter.

5. Have a designated well-lit private room to perform the screening assessments which must

be in close proximity to:

a) Hot and cold running water, and

b) A bathroom.

6. Obtain written parental/guardian consent:

a) The written consent must contain the following statements:

1) Parent/guardian right to be present during EPSDT screenings,

2) The physical examination will be unclothed,

3) The EPSDT screenings take the place of the yearly wellness exam performed at the beneficiary's primary care provider's office, and

4) Vaccines will be administered, if applicable,

b) Must include a space for the parent/guardian signature and date giving approval for the EPSDT screenings to be performed, and

c) Must be received within sixty (60) days prior to the EPSDT screenings.

7. Encourage the parent/guardian to be present during the EPSDT screenings,

8. Follow-up with the parent/guardian on the results of the screening by mail or in a one-on-one meeting.

9. Utilize the anticipatory guidance materials that are:

a) Age appropriate,

b) Mailed to the parent/guardian for beneficiaries under the age of fourteen (14).

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J. The Division of Medicaid does not reimburse for services other than EPSDT screenings in an off-site location.

Source: 42 U.S.C. §1396d; 42 C.F.R Part 441, Subpart B; Miss. Code Ann. §§ 43-13-117, 43-13-121.

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1. Developmental screenings according to the American Academy of Pediatrics (AAP) guidelines,

2. Vision screenings,

3. Hearing screenings,

4. Autism screenings,

5. Depression screenings,

6. Maternal depression screening, and

7. Other medically necessary services prior authorized by the Division of Medicaid or designee, if required:

   a) Lab tests, excluding hemoglobin or hematocrit,

   b) Diagnostic tests, and

   c) Other procedures.

B. The Division of Medicaid reimburses EPSDT screening fees using Current Procedural Terminology (CPT) Codes based on the American Medical Association (AMA) methodology for determining medical services at ~~ninety (90) percent of the Medicare physician fee schedule~~the same rate that was in effect for State Fiscal Year (SFY) 2021.~~ per state law.~~

C. The Division of Medicaid only reimburses Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC) and Mississippi Department of Health (MSDH) Clinics an encounter rate that is all inclusive of all items listed in Miss. Admin. Code Title 23, Part 223, Rule 1.8.A.

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A. The Division of Medicaid uses rate setting as a prospective method of reimbursement on both the state and federal level. This method does not allow for retrospective settlements. The rates are determined from cost reports and appropriate audits.

B. Standard rates will ~~be re-determined annually~~ remain the same as those in effect for State Fiscal Year (SFY) 2021. The Division of Medicaid uses a fee-for-service reimbursement rate which will remain the same as those in effect for State Fiscal Year 2021 for private providers. In no case may the reimbursement rate for services provided exceed an individual facility's customary charge to the public for such services in the aggregate, except for those public facilities rendering such services free of charge or at a nominal charge.

C. Payments under the plan do not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

D. Case management providers are paid on a unit of service basis that does not exceed fifteen (15) minutes.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(19)(b); 34 CFR 303

History: Revised eff. 07/01/2021.

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A. The Division of Medicaid defines:

1. Clinical/medical case record as the central repository of all pertinent information about the beneficiary that provides an accurate chronological accounting of the treatment plan and progress.

2. Day treatment as a behavioral intervention and strengths-based program, provided in the context of a therapeutic milieu, which enables beneficiaries between the ages of three (3) and twenty-one (21) with serious emotional disturbances or autism/Asperger's syndrome to live in the community.

3. A developmental evaluation as an assessment by a licensed practitioner utilizing standardized developmental instruments of the current cognitive, social and motor function of beneficiaries younger than three (3) years of age or beneficiaries with such severe mental or physical disabilities that a standardized intellectual assessment is not possible.

4. Duplication of services as the provision of the same service to the same beneficiary by the same or different provider on the same day.

~~5. Mississippi Youth Programs Around the Clock (MYPAC) services as home and community-based services for EPSDT-eligible beneficiaries with a serious emotional disturbance (SED) that meet the level of care provided in a psychiatric residential treatment facility (PRTF).~~

5~~6~~. A neuropsychological evaluation as a performance-based method to assess cognitive functioning which includes the collection of diagnostic information, differential diagnostic information, assessment of treatment response, and prediction of functional potential and recovery potential.

6~~7~~. Wraparound facilitation as a targeted case management program that includes the creation and facilitation of a child/youth and family team for the purpose of developing a single care plan to address the needs of children/youth with complex mental health challenges and their families.

B. Service definitions in Miss. Admin. Code Title 23, Part 206, Rule 1.3 are applicable to this Part.

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

History: Revised eff. 07/01/2021; New rule (to correspond with SPA 20-0022 eff. 09/01/2020) eff. 11/01/2020.

Rule 6.2: Provider Requirements

A. Providers of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Rehabilitative Services must comply with the provider requirements described in Miss. Admin. Code Title 23, Part 206, Rule 1.1.

B. Providers employing any evidence-based practices (EBP) in the course of treatment must have completed the appropriate training for the specific EBP.

C. Wraparound facilitators must be certified by the Mississippi Department of Mental Health (DMH).

~~D. Mississippi Youth Programs Around the Clock (MYPAC) providers must comply with the requirements in Miss. Admin. Code Title 23, Part 200, Rule 4.8 and meet the following provider specific requirements:~~

~~1. Submit a completed MYPAC project plan and enter into a provider agreement with the Division of Medicaid to become a MYPAC Medicaid Provider.~~

~~2. Ensure services are provided by staff acting within their scope of practice and in accordance the DMH's requirements.~~

~~3. Have a current Medicaid provider number.~~

4. Hold certification by DMH to provide:

    a) Wraparound facilitation services, and

    b) Community Support services.

5. Have a psychiatrist on staff.

6. Have or have contracted with appropriate clinical staff to provide needed therapy services.

7. 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.

8. Have written policies for documenting and reporting all critical incidents/occurrences which must include the following:

    a) Reporting of critical incidents in writing within one (1) business day to the Division of Medicaid with staff intervention responses and management of the critical incident.

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

    c) A written description of all critical events and actions.

    d) Documentation that explains follow-up, resolution, and debriefing.

9. Establish a grievance system that includes written policies and procedures.

    a) Inform the beneficiary and family of the grievance and appeals policies and procedures.

    b) Track and maintain record of all grievances and responses.

10. Have a written appeal process with policies and procedures which includes a Notice of Action.

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

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

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

~~12. Employ staff who meet the requirements in Miss. Admin. Code Title 23, Part 206 and DMH qualifications for the category of service they provide.~~

~~13. Conduct Quality Assurance activities to review each beneficiary's Wraparound Service Plan (WSP) and treatment outcomes.~~

~~14. Have the ability to provide face-to-face crisis response services twenty-four (24) hours per day, seven (7) days per week directly or through an arrangement with a crisis response team. Crisis response services may be provided in an emergency department of a hospital.~~

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

History: Revised eff. 07/01/2021; New rule (to correspond with SPA 20-0022 eff. 09/01/2020) eff. 11/01/2020.

Rule 6.3: Covered Services

A. All State Plan services described in Miss. Admin. Code Part 206 and Part 223 are covered for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)-eligible beneficiaries without regard to service limits when prior authorized by the Utilization Management/Quality Improvement Organization (UM/QIO).

B. The Division of Medicaid covers neuropsychological evaluations for EPSDT-eligible beneficiaries when medically necessary, prior authorized by a UM/QIO, the Division of Medicaid or designee and conducted by a psychologist trained to administer, score and interpret neuropsychological instruments, and one (1) or more of the following apply:

   1. Other interventions have been unsuccessful with the beneficiary,

   2. Previous psychological evaluation indicates neuropsychological deficits and supports justification,

   3. The beneficiary displays evidence of cognitive deficits or brain injury, or

   4. Results are used in treatment planning and placement decisions.

C. The Division of Medicaid covers developmental evaluations for EPSDT-eligible beneficiaries when medically necessary, prior authorized by a UM/QIO, the Division of Medicaid or designee, conducted by a physician or a psychologist with knowledge and expertise to administer and interpret developmental evaluation results and uses the results or the following:

   1. To assist in treatment planning for a beneficiary less than three (3) years of age or a beneficiary with a severe disability, or

   2. To confirm the existence of a major diagnosis.

D. The Division of Medicaid covers day treatment services for EPSDT eligible beneficiaries when the service and provider meet the following requirements:

1. Service components include:

a) Treatment plan development and review.

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

2. Certified to operate by the Mississippi Department of Mental Health (DMH).

3. Included in a care plan approved by one (1) of the following: a psychiatrist, physician, psychologist, psychiatric mental health nurse practitioner (PMHNP), physician assistant (PA), licensed clinical social worker (LCSW), licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), licensed medical social worker (LMSW) or certified mental health therapist (CMHT).

4. Provided by a psychiatrist, physician, psychologist, PMHNP, PA, LCSW, LPC, LMFT, LMSW or CMHT.

5. Prior authorized as medically necessary by the UM/QIO.

~~D~~E. The Division of Medicaid covers medically necessary wraparound facilitation as part of a targeted case management benefit for EPSDT-eligible beneficiaries with a serious emotional disturbance (SED) that meet the level of care provided in a psychiatric residential treatment facility (PRTF).~~wraparound facilitation services for EPSDT eligible beneficiaries when the service and provider meet the following requirements:~~

1. Service components include:

a) Engaging the family,

b) Assembling the beneficiary and family team which includes all of the required entities and individuals described in the DMH operational standards.

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

d) Facilitating the development of a wraparound service plan (WSP) through decisions made by the beneficiary and family team during the beneficiary and family team meeting, including a plan for anticipating, preventing and managing crisis,

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

f) Making necessary referrals for beneficiaries,

g) Documenting and maintaining all information regarding the WSP, including revisions and beneficiary and family team meetings,

h) Presenting WSP for approval to the beneficiary and family team,

i) Providing copies of the WSP to the entire team including the beneficiary and family/guardian,

j) Monitoring the implementation of the WSP and revising as necessary to achieve outcomes,

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

l) Evaluating the progress toward needs being met to ensure the referral behaviors have decreased,

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

n) Educating new team members about the wraparound process,

o) Maintaining team cohesiveness,

p) Meeting face-to-face with the ~~a MYPAC~~ beneficiary once a week,

q) Meeting face-to-face with the family twice a month,

r) Meeting with other collateral contacts related to WSP implementation at least three (3) times a week, and

s) Ensuring medication and management and monitoring of ~~MYPAC~~ beneficiaries on medication(s) used in the treatment of the beneficiary's Serious Emotional Disturbance (SED) occur at a physician visit every ninety (90) days at a minimum.

2. Wraparound services are provided by a Certified Wraparound Facilitator.

3. The ISP must be approved by one (1) of the following team members: a psychiatrist, physician, psychologist, PMHNP, PA, LCSW, LPC, or LMFT.

~~4. Services are limited to two hundred (200) fifteen (15) minute units per state fiscal year.~~

~~E. The Division of Medicaid covers Mississippi Youth Programs Around the Clock (MYPAC) services when prior authorized by the Division of Medicaid, UM/QIO, or designee for EPSDT-eligible beneficiaries that meet the following requirements:~~

1. The beneficiary must be diagnosed by a psychiatrist or psychologist with a mental, behavioral or emotional disorder of sufficient duration to meet the diagnostic criteria for Serious Emotional Disturbance (SED) specified within the most current Diagnostic and Statistical Manual (DSM),

2. The beneficiary must be cognitively able to actively participate in the services recommended by the Wraparound Services Plan (WSP), or

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

4. Services include, but are not limited to:

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

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

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

    d) Wraparound facilitation that complies with DMH Operating Standards.

5. Development and implementation of an WSP.

    a) The WSP must include the following:

        (1) Services to be provided,

        (2) Frequency of service provision,

        (3) Staff providing each service and their qualifications,

        (4) Formal and informal supports available to the beneficiary and family, and

        (5) Plans for anticipating, preventing and managing crises.

    b) Each WSP must include an Individualized Crisis Management Plan (ICMP) which:

(1) Must be developed within one (1) day of admission to MYPAC services and updated when the comprehensive ICMP is developed during the first child and family team meeting.

(2) Identifies triggers that may lead to potential crisis or risk and interventions and strategies to avoid the crisis.

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

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

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

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

(7) Provides for crisis debriefing after the crisis has been resolved.

(8) Provides initial and updated copies of the WSP, ICMP and contacts to the beneficiary and family.

c) The wraparound facilitator must monitor the WSP continuously through face-to-face visits with the beneficiary and family.

(1) The child and family team must review the WSP at least every thirty (30) days during a child and family team meeting.

(2) The WSP must be updated or revised when warranted by changes in the beneficiary's needs.

(3) The full child and family team must participate in the development of the initial WSP, revisions of the WSP, and the discharge WSP.

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

6. Discharge/Transition Planning

a) Discharge planning must begin on the first day of admission and the MYPAC provider is responsible for assisting the family with transition plans through the wraparound process.

b) Discharge from MYPAC services occurs when the beneficiary:

(1) Reaches twenty-two (22) years of age or "ages out",

(2) Utilizes their freedom of choice to end MYPAC services, if applicable,

(3) Moves out of state,

(4) No longer meets the criteria or requires the level of care provided by MYPAC, or

(5) Is admitted to an acute care facility or PRTF.

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

d) 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 there is a change:

(1) MYPAC services begin and end date,

(2) Reason for discharge,

(3) Name of the person or agency that cares for and has custody of the beneficiary,

(4) Physical location/address where the beneficiary resides,

(5) List of the beneficiary's diagnoses,

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

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

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

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

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

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

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

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

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

History: Revised eff. 07/01/2021; New rule (to correspond with SPA 20-0022 eff. 09/01/2020) eff. 11/01/2020.

Rule 6.4: Non-Covered Services

A. The Division of Medicaid does not cover:

1. Educational interventions of an academic nature performed by the Department of Education,

2. Same service provided on the same date, regardless of the setting(s) in which the service was provided unless service specifically states otherwise.

3. Community-based mental health services when a beneficiary is an inpatient of a Medicaid-covered facility,

4. Time spent on documentation, unless completed during the session and relevant to the treatment goals,

5. Time spent completing a care plan form or prior authorization request online via web portal,

6. Staff travel time,

7. Field trips and routine recreational activities,

8. Beneficiary travel time to and from any service, or

9. Services provided to more than one (1) beneficiary at a time, unless specifically allowed in the service definition.

B. The Division of Medicaid does not cover the following evaluative services:

1. A neuropsychological evaluation when:

a) Only administered to rule out attention deficit hyperactivity disorder (ADHD), or

b) Previous evaluations did not support the suspicion of cognitive deficits or brain injury.

2. The Division of Medicaid does not cover a developmental evaluation when:

a) Referral questions can be adequately answered through behavioral observation and family interviews, or

b) A standardized intellectual assessment is appropriate and the beneficiary is three (3) years or older with no severe disabilities.

Source: ~~Section~~ Miss. Code Ann. § 43-13-117 ~~of the Mississippi Code of Federal Regulations of 1972, as amended~~.

History: Revised eff. 07/01/2021; New rule (to correspond with SPA 20-0022 eff. 09/01/2020) eff. 11/01/2020.

Rule 6.5: Reimbursement

A. The Division of Medicaid reimburses expanded rehabilitative services based on a statewide uniform fee schedule.

~~B. Providers are reimbursed an all-inclusive rate for beneficiaries receiving Mississippi Youth Programs Around the Clock (MYPAC) services.~~

~~1. Mental health services cannot be billed separately or by another provider for beneficiaries receiving MYPAC services.~~

~~2. MYPAC providers must coordinate with other providers of mental health services to ensure the beneficiary receives and providers are reimbursed for medically necessary services.~~

~~3. Services must be provided for at least thirty (30) minutes in one (1) day to receive the daily rate.~~

~~C. Providers must maintain documentation of each service billed to the Division of Medicaid to substantiate the claim.~~

B~~D~~. The Division of Medicaid does not reimburse for the duplication of services.

1. Providers are responsible for coordinating services with the beneficiary and guardian/legal representative to avoid service duplication when the beneficiary is receiving mental health services at more than one (1) location from more than one (1) provider.

2. When duplicate service claims are filed the provider billing the first claim is reimbursed.

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

History: Revised eff. 07/01/2021; New rule (to correspond with SPA 20-0022 eff. 09/01/2020) eff. 11/01/2020.

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 s~~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~~C. Documentation of services that are subject to certification by the Department of Mental Health (DMH) 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. 07/01/2021; Revised eff. 01/01/2021. New rule (to correspond with SPA 20-0022 eff. 09/01/2020) eff. 11/01/2020.