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. 08/01/2021; 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 to correspond with SPA 20-0017 (eff. 07/01/2021) eff. 08/01/2021; 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.

History: Revised to correspond with SPA 21-0028 (eff. 07/01/2021) eff. 08/01/2021; Revised to correspond with SPA 18-0014 (eff. 10/01/2018) effective 12/01/2018. New Rule to correspond with SPA 15-017 (eff. 11/01/2016) eff. 10/01/2016.

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.

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

History: Revised eff. 08/01/2021.

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 who require the level of care provided in a Psychiatric Residential Treatment Facility (PRTF).

B. Service definitions in Miss. Admin. Code Title 23, Part 206, Rule 1.2 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 to correspond with SPA 21-0039 (eff. 07/01/2021) eff. 08/01/2021; 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).

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 master 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 as described in the DMH operational standards for wraparound facilitation.

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) Contact with the beneficiary at least weekly,

q) Meeting face-to-face with the beneficiary a minimum of twice per month in addition to family face-to-face meetings,

r) Meeting face-to-face with the family a minimum of twice per month in addition to beneficiary face-to-face meetings,

s) Contact with collateral contacts related to WSP implementation and/or other care coordination activities at least three (3) times a week, and

t) Ensuring medication management and monitoring of beneficiaries 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.

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

History: Revised to correspond with SPA 21-0039 (eff. 07/01/2021) eff. 08/01/2021; 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 except for targeted case management services, including wraparound services, provided up to thirty (30) days of a covered stay in a medical institution for EPSDT-eligible beneficiaries with a serious emotional disturbance (SED) that meet the level of care provided in a psychiatric residential treatment facility (PRTF),

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.

C. The Division of Medicaid does not cover case management services that:

1. Restrict a beneficiary's access to other services under the State Plan.

2. Require the beneficiary to receive other Medicaid services as a condition of receipt of case management services.

3. Duplicates other services provided by public agencies or private entities.

4. Authorize or deny the provision of other services under the State Plan.

5. Constitute the direct delivery of underlying medical, educational, social or other services to which a beneficiary has been referred.

Source: 42 C.F.R. § 441.18; Miss. Code Ann. § 43-13-117.

History: Revised to correspond with SPA 21-0039 (eff. 07/01/2021) eff. 08/01/2021; 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.

C. The Division of Medicaid reimburses a monthly fee for 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).

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

History: Revised to correspond with SPA 21-0039 (eff. 07/01/2021) eff. 08/01/2021; 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 to correspond with SPA 21-0039 (eff. 07/01/2021) eff. 08/01/2021; 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

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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.

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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 to correspond with SPA 20-0017 (eff. 07/01/2021) eff. 08/01/2021~~Revised eff. 07/01/2021~~; Revised eff. 11/01/2020; Revised to correspond with SPA 18-0014 (eff.

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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.

History: Revised to correspond with SPA 21-0028(eff. 07/01/2021) eff. 08/01/2021; Revised to correspond with SPA 18-0014 (eff. 10/01/2018) effective 12/01/2018. New Rule to correspond with SPA 15-017 (eff. 11/01/2016) eff. 10/01/2016.

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. 0~~8~~7/01/2021.

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~~who require the level of care provided in a Psychiatric Residential Treatment Facility (PRTF) .

B. Service definitions in Miss. Admin. Code Title 23, Part 206, Rule 1.2~~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 to correspond with SPA 21-0039 (eff. 07/01/2021) eff. 08/01/2021; 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).

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~~ master 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 as described in the DMH operational standards for wraparound facilitation.

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) Contact with the beneficiary at least weekly,

q~~p~~) Meeting face-to-face with the beneficiary a minimum of twice per month~~once a week~~ in addition to family face-to-face meetings,

r~~q~~) Meeting face-to-face with the family a minimum of twice per ~~a~~ month in addition to beneficiary face-to-face meetings,

s~~r~~) ~~Meeting~~ Contact with ~~other~~ collateral contacts related to WSP implementation and/or other care coordination activities at least three (3) times a week, and

t~~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 to correspond with SPA 21-0039 (eff. 07/01/2021) eff. 08/01/2021;~~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 except for targeted case management services, including wraparound services, provided up to thirty (30) days of a covered stay in a medical institution for EPSDT-eligible beneficiaries with a serious emotional disturbance (SED) that meet the level of care provided in a psychiatric residential treatment facility (PRTF),

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.

C. The Division of Medicaid does not cover case management services that:

1. Restrict a beneficiary's access to other services under the State Plan.

2. Require the beneficiary to receive other Medicaid services as a condition of receipt of case management services.

3. Duplicates other services provided by public agencies or private entities.

4. Authorize or deny the provision of other services under the State Plan.

5. Constitute the direct delivery of underlying medical, educational, social or other services to which a beneficiary has been referred.

Source: 42 C.F.R. § 441.18; Miss. Code Ann. § 43-13-117.

History: Revised to correspond with SPA 21-0039 (eff. 07/01/2021) eff. 08/01/2021; ~~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.

C. The Division of Medicaid reimburses a monthly fee for 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).

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

History: Revised to correspond with SPA 21-0039 (eff. 07/01/2021) eff. 08/01/2021;~~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 to correspond with SPA 21-0039 (eff. 07/01/2021) eff. 08/01/2021;~~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.