Title 23: Division of Medicaid

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

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).

7. Mississippi Youth Programs Around the Clock (MYPAC) Therapeutic services as a community psychiatric support treatment program provided in the home or community, to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) eligible beneficiaries that require the level of care provided in a psychiatric residential treatment facility (PRTF), for family stabilization to empower the beneficiary to achieve the highest level of functioning. These are a group of therapeutic interventions designed to diffuse the current crisis, evaluate its cause, and intervene to reduce the likelihood of a recurrence.

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 21-0028 (eff. 07/01/2021) eff. 03/01/2024; 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) and comply with the DMH Operational Standards for Mental Health, Intellectual/Developmental Disabilities and Substance Use Community Service Providers established for Wraparound service provision.

D. MYPAC therapeutic services must be provided by a Mississippi Department of Mental Health certified provider within the scope of their license and/or certification and comply with the DMH Operational Standards for Mental Health, Intellectual/Development Disabilities, and Substance Use Community Service Providers established for MYPAC service provision.

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 21-0028 (eff. 07/01/2021) eff. 03/01/2024; 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.

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

F. The Division of Medicaid covers medically necessary Mississippi Youth Programs Around the Clock (MYPAC) Therapeutic Services for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) eligible beneficiaries that require the level of care provided in a psychiatric residential treatment facility (PRTF).

1. In order to receive MYPAC Therapeutic Services, beneficiaries must meet DMH requirements for admission.

2. Providers of MYPAC Therapeutic Services must be certified by DMH to provide MYPAC Therapeutic Services.

3. MYPAC Therapeutic Services must be provided to beneficiaries based on the beneficiary's needs as identified as a part of the wraparound plan of care or individual service plan.

4. MYPAC Therapeutic Services are designed to meet the clinical needs of the beneficiaries and families. Component parts of MYPAC Therapeutic Services must also be certified by DMH if applicable certification is available. Services should meet all DMH service provision requirements. These components include:

a) Treatment plan development and review which is defined as the development and review of an overall plan that directs the treatment and support of the person receiving services by qualified providers.

b) Medication management which includes the evaluation and monitoring of psychotropic medications, provided by a psychiatrist, or psychiatric mental health nurse practitioner.

c) Intensive individual therapy defined as one-on-one therapy for the purpose of treating a mental disorder and family therapy defined as therapy for the family which is exclusively directed at the beneficiary's needs and treatment provided in the home.

d) Family therapy involves participation of non-Medicaid eligible individuals for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service. Must be provided by a master's level staff.

e) Peer support services defined as non-clinical activities with a rehabilitation and resiliency/recovery focus that allow a person receiving mental health services and/or substance use disorders services and their family members the opportunity to build skills for coping with and managing psychiatric symptoms, substance use issues and challenges associated with various disabilities while directing their own recovery. Must be provided by a certified Peer Support Specialist.

g) Community Support Services defined as specific, measurable and individualized that focuses on the mental health needs of the beneficiary while attempting to restore beneficiary's ability to succeed in the community. Covered community support services include:

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

2) Individual therapeutic interventions that directly increase the restoration of skills needed to accomplish the goals set forth in the Individual Service Plan.

3) Monitoring and evaluating the effectiveness of interventions that focus on restoring, retraining and reorienting, as evidence by symptom reduction and program toward goals.

4) Psychoeducation regarding the identification and self-management of the prescribed medication regimen and communication with the prescribing provider.

5) Direct interventions in deescalating situations to prevent crisis.

6) Relapse prevention.

7) Facilitation of the Individual Service Plan or Recovery Support Plan which includes the active involvement of the beneficiary and the people identified as important in the beneficiary's life.

5. Each beneficiary receiving MYPAC Therapeutic Services must have on file an individualized plan which describes the following:

a) Services to be provided,

b) Frequency of service provision,

c) Who provides each service and their qualifications,

d) Formal and informal supports available to the beneficiary and family,

e) Plan for anticipating, preventing and managing crises, and

f) A discharge or transition plan.

6. If the beneficiary participates in Targeted Case Management provided as Wraparound Facilitation, the MYPAC provider agency must be a participating team member and attend the monthly Child Family Team Meeting.

7. MYPAC Therapeutic Services must be prior authorized as medically necessary by the UM/QIO.

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 21-0028 (eff. 07/01/2021) eff. 03/01/2024; 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.

10. Wraparound facilitation for more than one family member at a time.

11. Case management components provided or billed as part of a direct care service, including but not limited to:

    a) Assisting a person in accessing needed services such as medical, social, educational, transportation, housing, substance use, personal care, employment and other services that may be identified in the Recovery Support Plan as components of Health, Home, Purpose and Community,

    b) Assisting the person and natural supports in implementation of therapeutic interventions outlined in the Individual Service Plan, or

    c) Psychoeducation and training of family, unpaid caregivers, and/or others who have a legitimate role in addressing the needs of the person.

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 21-0028 (eff. 07/01/2021) eff. 03/01/2024; 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).

D. The Division of Medicaid reimburses an hourly rate and additional time in fifteen (15) minute units for Mississippi Youth Program Around the Clock (MYPAC) Therapeutic Services.

1. Beneficiaries must be provided a choice of the following:

a) MYPAC therapeutic services or individual therapeutic services,

b) The provider of the services and

c) The team members included in service planning.

2. The Division of Medicaid does not reimburse for services included in MYPAC Therapeutic Services individually during the time period the beneficiary has chosen to receive MYPAC Therapeutic Services.

3. Service provision must, at a minimum, be one (1) hour per day to be reimbursed for the services.

   a) The initial hour must be billed as four (4) fifteen (15) minute units.

   b) After the initial hour, fifteen (15) minute units may be billed based on actual time of service provision as medically necessary and with appropriate documentation.

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 21-0028 (eff. 07/01/2021) eff. 03/01/2024; 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, and

   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, and

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.

D. Providers must document, in writing with the legal guardian's signature, that beneficiaries were given a free choice, which must include freedom of choice for:

1. The type of services,

2. The provider of services, and

3. The team members included in service planning.

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 21-0028 (eff. 07/01/2021) eff. 03/01/2024; 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 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).

7. Mississippi Youth Programs Around the Clock (MYPAC) Therapeutic services as a community psychiatric support treatment program provided in the home or community, to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) eligible beneficiaries that require the level of care provided in a psychiatric residential treatment facility (PRTF), for family stabilization to empower the beneficiary to achieve the highest level of functioning. These are a group of therapeutic interventions designed to diffuse the current crisis, evaluate its cause, and intervene to reduce the likelihood of a recurrence.

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 21-0028 (eff. 07/01/2021) eff. ~~04~~03/01/2024~~2~~; 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) and comply with the DMH Operational Standards for Mental Health, Intellectual/Developmental Disabilities and Substance Use Community Service Providers established for Wraparound service provision.

D. MYPAC therapeutic services must be provided by a Mississippi Department of Mental Health certified provider within the scope of their license and/or certification and comply with the DMH Operational Standards for Mental Health, Intellectual/Development Disabilities, and Substance Use Community Service Providers established for MYPAC service provision.

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 21-0028 (eff. 07/01/2021) eff. ~~04~~03/01/~~2022~~2024; 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.

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

F. The Division of Medicaid covers medically necessary Mississippi Youth Programs Around the Clock (MYPAC) Therapeutic Services for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) eligible beneficiaries that require the level of care provided in a psychiatric residential treatment facility (PRTF).

1. In order to receive MYPAC Therapeutic Services, beneficiaries must meet DMH requirements for admission.

2. Providers of MYPAC Therapeutic Services must be certified by DMH to provide MYPAC Therapeutic Services.

3. MYPAC Therapeutic Services must be provided to beneficiaries based on the beneficiary's needs as identified as a part of the wraparound plan of care or individual service plan.

4. MYPAC Therapeutic Services are designed to meet the clinical needs of the beneficiaries and families. Component parts of MYPAC Therapeutic Services must also be certified by DMH if applicable certification is available. Services should meet all DMH service provision requirements. These components include:

a) Treatment plan development and review which is defined as the development and review of an overall plan that directs the treatment and support of the person receiving services by qualified providers.

b) Medication management which includes the evaluation and monitoring of psychotropic medications, provided by a psychiatrist, ~~physician, physician assistant~~ or psychiatric mental health nurse practitioner.

c) Intensive individual therapy defined as one-on-one therapy for the purpose of treating a mental disorder and family therapy defined as therapy for the family which is

exclusively directed at the beneficiary's needs and treatment provided in the home.

d) -Family therapy involves participation of non-Medicaid eligible individuals for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service. Must be provided by a master's level staff.

~~d) Group therapy defined as face-to-face therapy addressing the needs of several beneficiaries within a group, provided by a master's level staff.~~

e) Peer support services defined as non-clinical activities with a rehabilitation and resiliency/recovery focus that allow a person receiving mental health services and/or substance use disorders services and their family members the opportunity to build skills for coping with and managing psychiatric symptoms, substance use issues and challenges associated with various disabilities while directing their own recovery. Must be provided by a certified Peer Support Specialist.

g) ~~Skill building groups such as social skills training, self-esteem building, anger control, conflict resolution and daily living skills.~~Community Support Services defined as specific, measurable and individualized that focuses on the mental health needs of the beneficiary while attempting to restore beneficiary's ability to succeed in the community. Covered community support services include:

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

2) Individual therapeutic interventions that directly increase the restoration of skills needed to accomplish the goals set forth in the Individual Service Plan.

3) Monitoring and evaluating the effectiveness of interventions that focus on restoring, retraining and reorienting, as evidence by symptom reduction and program toward goals.

4) Psychoeducation regarding the identification and self-management of the prescribed medication regimen and communication with the prescribing provider.

5) Direct interventions in deescalating situations to prevent crisis.

6) Relapse prevention.

7) Facilitation of the Individual Service Plan or Recovery Support Plan which includes the active involvement of the beneficiary and the people identified as important in the beneficiary's life.

5. Each beneficiary receiving MYPAC Therapeutic Services must have on file an individualized plan which describes the following:

    a) Services to be provided,

    b) Frequency of service provision,

    c) Who provides each service and their qualifications,

    d) Formal and informal supports available to the beneficiary and family,

    e) Plan for anticipating, preventing and managing crises, and

    f) A discharge or transition plan.

6. If the beneficiary participates in Targeted Case Management provided as Wraparound Facilitation, the MYPAC provider agency must be a participating team member and attend the monthly Child Family Team Meeting.

7. MYPAC Therapeutic Services must be prior authorized as medically necessary by the UM/QIO.

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 21-0028 (eff. 07/01/2021) eff. ~~04~~03/01/~~2022~~2024; 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.

10. Wraparound facilitation for more than one family member at a time.

11. Case management components provided or billed as part of a direct care service, including but not limited to:

    a) Assisting a person in accessing needed services such as medical, social, educational, transportation, housing, substance use, personal care, employment and other services that may be identified in the Recovery Support Plan as components of Health, Home, Purpose and Community,

    b) Assisting the person and natural supports in implementation of therapeutic interventions outlined in the Individual Service Plan, or

    c) Psychoeducation and training of family, unpaid caregivers, and/or others who have a legitimate role in addressing the needs of the person.

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 21-0028 (eff. 07/01/2021) eff. ~~04~~03/01/~~2022~~2024; 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).

D. The Division of Medicaid reimburses an hourly rate and additional time in fifteen (15) minute units ~~per diem~~ for Mississippi Youth Program Around the Clock (MYPAC) Therapeutic Services.

1. Beneficiaries must be provided a choice of the following:

a) MYPAC therapeutic services or individual therapeutic services,

b) The provider of the services and

c) The team members included in service planning.

2. The Division of Medicaid does not reimburse for services included in MYPAC Therapeutic Services individually during the time period the beneficiary has chosen to receive MYPAC Therapeutic Services.

3. Service provision must, at a minimum, be one (1) hour per day to be reimbursed for the services.

a) The initial hour must be billed as four (4) fifteen (15) minute units.

b) After the initial hour, fifteen (15) minute units may be billed based on actual time of service provision as medically necessary and with appropriate documentation.

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 21-0028 (eff. 07/01/2021) eff. ~~04~~03/01/~~2022~~2024; 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, and

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, and

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.

D. Providers must document, in writing with the legal guardian's signature, that beneficiaries were given a free choice, which must include freedom of choice for:

1. The type of services,

2. The provider of services, and

3. The team members included in service planning.

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 21-0028 (eff. 07/01/2021) eff. ~~04~~03/01/~~2022~~2024; 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.