



MISSISSIPPI DIVISION OF
MEDICAID

Administrative Code

Title 23: Medicaid
Part 206
Mental Health Services

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Title 23: Division of Medicaid

Part 206: Mental Health Services

Part 206 Chapter 1: Community Mental Health Services

Rule 1.1 General

A. Purpose

The purpose of these regulations is to set forth the minimum requirements for providers who provide described mental health services to Medicaid beneficiaries in a community mental health setting. These regulations also provide for the maximum number of services that may be provided to a beneficiary daily and annually. Any service that requires prior authorization by the Division of Medicaid is so specified. The regulations have been prepared for the information and guidance of providers of services participating in the Mississippi Medicaid program.

It is the provider's responsibility to assure that the business's employees at all locations are knowledgeable of the Medicaid program requirements and have access to Medicaid regulation, requirements, and other information pertinent to the performance of their duties.

B. Legal Authority

The Division of Medicaid is authorized to promulgate these rules under and by virtue of Section 43-13-121 of the Mississippi Code of 1972, as amended.

As specified in 43-13-117 (16) of the Mississippi Code of 1972, as amended, Community Mental Health Services described in these regulations are approved therapeutic and case management services provided by (a) an approved regional mental health/retardation center established under Sections 41-19-31 through 41-19-39, or by another community mental health service provider meeting the requirements of the Department of Mental Health (DMH) to be an approved mental health/retardation center if determined necessary by DMH, using state funds which are provided from the appropriation to DMH and used to match federal funds under a cooperative agreement between the division and the department, or (b) a facility certified by DMH to provide therapeutic and case management services, to be reimbursed on a fee for service basis. Any such services provided by a facility described in paragraph (b) must have the prior authorization of the Division to be eligible for reimbursement under this section. Any facility described in paragraph (b) must be certified by DMH as a community mental health center and matching funds for services will be funded by DMH.

C. Coverage Criteria

1. The Division of Medicaid will provide coverage for covered mental health services when it is determined that the medically necessary criteria and guidelines listed below are met.

“Medically necessary” or “medical necessity” shall mean health care services that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- a) Appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the patient’s medical condition,
 - b) Compatible with the standards of acceptable medical practice in the United States,
 - c) Provided in a safe, appropriate and cost-effective community-based setting given the nature of the diagnosis and the severity of the symptoms,
 - d) Not provided solely for the convenience of the beneficiary or family, or the convenience of any health care provider,
 - e) Not primarily custodial care,
 - f) There is no other effective and more conservative or substantially less costly treatment service and setting available,
 - g) The service is not experimental, investigational or cosmetic in nature, and
 - h) All Mississippi Medicaid regulations, program rules, exclusions, limitations, and service limits, etc., apply. The fact that a service is medically necessary does not, in itself, qualify the service for reimbursement.
2. Reimbursement is available only for beneficiaries who have Medicaid eligibility for the date the service is provided.
 3. Mental Health Services in this Chapter are covered for adult or child beneficiaries of Mississippi Medicaid. Services available to targeted populations only are specified under the appropriate Rule.

D. General Service Requirements

1. Services provided must comply with rules, guidelines and regulations established by the Division of Medicaid.
2. All providers enrolled as community mental health providers must be certified for the provision of the mental health services they provide by the Department of Mental Health on the date of service.
3. Staff providing mental health services must meet minimum qualifications as established by the Division of Medicaid. A staff member must hold at a minimum, a bachelor’s degree in a mental health field, in order to provide services billed to Medicaid unless

specifically stated in a rule defining a service. Bachelor's level staff shall not provide therapy services.

4. There must be clear evidence provided in the documentation that services are based on beneficiary need and not convenience of the staff.
5. Beneficiaries shall not be required to participate in services that are not medically necessary or there is no identified need. Beneficiaries shall not be required to participate in one service in order to get another. Determination of needed services must be person-centered.
6. An individual staff member can bill only for the actual time spent in service delivery, not to exceed the amount of total time the staff member actually worked. Staff may not spend the least amount of time possible to equal a billing unit in order to bill nine (9) hours per day when only eight (8) hours were worked.
7. Where there are conflicts between this Administrative Rule, the Division of Medicaid provider manuals and fee schedules or the DMH Standards, the Division of Medicaid Administrative Rule supersedes all else.
8. Interpretations to the Medicaid rules and regulations, including the Mississippi Medicaid Administrative Rule, must be received in writing from the Division of Medicaid. The Division of Medicaid is the only agency that has the authority to render a decision on Medicaid Administrative Rule or other guidance documents.

E. Documentation Requirements

1. All services billed to Medicaid must be included in the treatment plan and must be approved by a licensed independent practitioner in accordance with the appropriate scope of practice. These practitioners are limited to: a Mississippi licensed Physician who holds a specialty in psychiatry, a Mississippi licensed physician with minimum of five (5) years experience in mental health, a Mississippi licensed Psychologist, a Mississippi Licensed Certified Social Worker (LCSW), a Mississippi Licensed Professional Counselor (LPC), a Mississippi Licensed Marriage and Family Therapist (LMFT), a Psychiatric Mental Health Nurse Practitioner under an approved protocol, or a Physician Assistant.
2. For the purpose of this rule, a treatment plan may be referred to as the plan of care, individualized service plan, wraparound plan or person-centered plan depending on the service. It is the plan that directs the treatment of the Medicaid beneficiary.
3. Each initial and updated treatment plan must be reviewed, signed and dated by an approved practitioner as listed in E.1.
4. Each service provided and billed to Medicaid must have corresponding documentation to substantiate the claim, be in the case record and must, at a minimum, include the following documentation:

- a) Type of service provided (group therapy, family therapy, individual therapy, etc.),
 - b) Date (DD/MM/YYYY) of service,
 - c) Length of time (00:00) spent delivering the service,
 - d) Time session began and time session ended,
 - e) Identification of individual (s) receiving or participating in the service,
 - f) Summary of what transpired in the session,
 - g) Evidence the session relates to the goals and objectives established in the treatment plan,
 - h) Name and title of staff who provided the service,
 - i) Signature and credentials of the person who provided and documented the service, and
 - j) Legible documentation that can easily be read by reviewers.
5. Community Mental Health services must be documented according to the DMH Record Guide in effect on the date of service for a particular service.

F. Non-covered services

1. The following activities are ineligible for reimbursement by Medicaid:
 - a) Paperwork completed outside of a direct service provision.
 - b) Telephone contacts, unless specified in the service definition.
 - c) Field trips and routine recreational activities.
 - d) Educational intervention.,
 - e) Staff travel time.
 - f) Transportation of individuals receiving mental health services.
 - g) Beneficiary travel time to or from any CMH service.
 - h) Failed and/or canceled appointments. The provider is prohibited from billing the Medicaid beneficiary for the missed appointment.

- i) Evaluation or review of beneficiary progress outside of treatment team or as a function of targeted case management.
- j) CMH services when a beneficiary is an inpatient in an inpatient facility (ex: a medical hospital, an acute freestanding psychiatric facility, or a psychiatric residential treatment facility).
- k) Service provided simultaneous with any other Medicaid-covered service, unless specifically allowed in the service definition.
- l) Services provided to more than one beneficiary at a time, unless specifically allowed in the service definition.
- m) Services in a nursing facility if not approved by the Appropriateness Review Committee as part of the Preadmission Screening and Resident Review Process required by 42 CFR 483, Subpart C.

2. Providers are strongly cautioned not to submit claims for ineligible activities.

Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

Rule 1.2 Psychosocial Assessment and Psychological Evaluation

- A. Assessment is the securing, from the beneficiary and/or collateral, of the beneficiary's family background/ educational/vocational achievement, presenting problem(s), problem history, history of previous treatment, medical history, current medication(s), source of referral and other pertinent information in order to determine the nature of the individual's or family's problem(s), the factors contributing to the problem (s), and the most appropriate course of treatment for the beneficiary.
 - 1. A completed Biopsychosocial Assessment form, which includes the signature and credentials of the staff member who conducted the assessment, must be present in the case record.
 - 2. Psychosocial assessment may be completed at the time of intake and as needed for reassessment.
 - 3. All psychosocial assessments must be provided by a staff member who holds a master's degree and professional license (ex.: Physician, Psychologist, Licensed Certified Social Worker, Licensed Master Social Worker, Licensed Professional Counselor or Licensed Marriage & Family Therapist) or who is a DMH Certified Mental Health Therapist, DMH Certified Intellectual and Developmental Disabilities Therapist or a DMH Certified Addiction Therapist (when appropriate for the individual receiving service and the service provided).

4. Those who are provisionally certified must be supervised by a licensed professional or a credentialed DMH Certified Mental Health Therapist, DMH Certified Intellectual and Development Disabilities Therapist or DMH Certified Addiction Therapist. The supervisor must be of the same discipline as those they supervise.
 5. Psychosocial assessment is limited to four (4) assessments per state fiscal year.
- B. Psychological Evaluations are the assessment of a beneficiary's cognitive, emotional, behavioral, and social functioning by a licensed psychologist using standardized tests, interviews, and behavioral observations.
1. A psychological evaluation may be eligible for Medicaid reimbursement when one (1) or more of the following conditions exist:
 - a) There is a history of unexplained treatment failures.
 - b) There are questions regarding diagnosis and/or treatment that a psychological evaluation might help to answer.
 - c) Evaluation is required by the Division of Medicaid for admission to a psychiatric residential treatment facility (PRTF).
 2. Reasons a psychological evaluation may be eligible for reimbursement include, but are not limited to the following:
 - a) The need to confirm or rule out the existence of a major diagnosis, such as depression, psychosis, mental retardation, or Attention Deficit Hyperactivity Disorder (ADHD) when behavioral observation and history supports the suspected diagnosis.
 - b) The existence of a pattern of inability to learn, but not to the extent that the beneficiary qualifies for evaluation for Special Education services.
 - c) The need to assess a beneficiary's potential for success in a certain type of program.
 3. A psychological evaluation is not eligible for reimbursement through Medicaid when any of the following conditions apply:
 - a) It is provided as a routine procedure or requirement of any program or provider, including pre-commitment hearings.
 - b) It is to determine educational needs/problems when such assessment is the responsibility of the school system where the child is enrolled.
 - c) It is within one (1) year of a previous psychological evaluation, unless necessary for admission to a Medicaid-certified PRTF or community based alternatives to PRTF or

if needed to assess progress in a beneficiary with an evolving condition (i.e., head injury, severe depression).

4. Provider Requirements - Psychological evaluations must be completed in their entirety by a psychologist who is licensed to practice independently by the Mississippi Board of Psychology or the licensing board for psychologists in the state the service is provided.
5. Psychological evaluations are limited to four (4) hours per state fiscal year.
6. In order for a psychological evaluation to be eligible for Medicaid reimbursement, the psychologist completing the psychological evaluation must ensure that all of the following occur:
 - a) Psychological testing is indicated by the referral question. If it is not, it is the responsibility of the psychologist to educate the referral source as to those circumstances in which testing is or is not indicated.
 - b) An initial session must be held with the beneficiary and beneficiary's family before any testing is initiated. It may occur immediately preceding the psychological testing. The purpose of this session is to determine the medical necessity of psychological evaluation and to gather background information. Collateral contact may be included in the background and information gathering session, and the time spent with those collateral contacts is eligible for Medicaid reimbursement only when that contact is face-to-face. If it becomes apparent during the session that the beneficiary and/or family would benefit from certain strategies/interventions (e.g., bibliotherapy, behavioral approaches for beneficiaries with attention difficulties), these interventions should be implemented and their effectiveness evaluated before the necessity of testing is reconsidered. Though part of the evaluation process, the background and information gathering session should be billed as either a biopsychosocial assessment or family therapy (with or without the beneficiary, as appropriate).
 - c) The psychologist has appropriate training, experience and expertise to administer, score and interpret those instruments used.
 - d) The instruments used are psychometrically valid and appropriate to the referral question, the beneficiary's age and any special conditions presented by the beneficiary and/or the testing situation. In those instances in which more than one instrument could be used (e.g., IQ testing), the psychologist chooses the most psychometrically sound one unless otherwise indicated by the unique characteristics of the test-taker (e.g., the beneficiary is non-English speaking, physically unable to manipulate materials).
 - e) Unless doing so would present a hardship to the beneficiary and family, the beneficiary's family and, when appropriate, the beneficiary are provided with face-to-face (when possible) verbal feedback regarding test results, interpretation and recommendations within fourteen (14) calendar days of the written report. The

referral source is included if requested at the time of the referral. The beneficiary's family and the beneficiary shall be given adequate opportunity to ask questions and give their input regarding the evaluation feedback. If face-to-face feedback is not possible, feedback is provided through alternative means. However, as part of the evaluation process, the feedback session should be billed as family therapy, with or without the beneficiary present, as appropriate.

7. Documentation Requirements

- a) If/when testing is indicated, the testing process and the written report must document the medical necessity, adequately address the referral question, and reflect an understanding of the background strengths, values and unique characteristics of the beneficiary and family.
 - b) A written report must be generated within thirty (30) calendar days of completion of the assessment. However, if the beneficiary's treatment needs indicate an earlier report deadline, the report is generated as soon as possible. The report synthesizes the information gathered through interviews, observation, and standardized testing, including a discussion of any cautions related to testing conditions or limitations of the instruments used.
 - c) The written report must provide practical recommendations for those working with the beneficiary. These recommendations should reflect recognition of the beneficiary and family's strengths as well as their areas of need.
 - d) If computer-generated scoring or interpretation reports are used as one source of data, they must be integrated into the report as whole. Reports that include computer generated feedback without this integration are unacceptable.
 - e) Concrete plans are made for follow-up based on evaluation recommendations and feedback from the referral source, the family and, when appropriate, the beneficiary (e.g., therapy appointment is made, the family is given information about mentoring programs), and these plans are documented in writing.
 - f) Information obtained from collateral contacts is included in the report.
 - g) Documentation of evaluative services must include the dates and amount of time spent, including beginning and ending session times, in assessment/testing and the amount of time spent preparing a report. Evaluation reports must be dated and signed by the provider who conducted the evaluation.
- C. Treatment Plan Review is the process through which a group of clinical staff meets to discuss with the beneficiary and his/her family members the individual's treatment plan. The review will utilize a strengths-based approach and shall address strengths and natural resources, presenting symptoms/problems, diagnostic impressions, and initiate/update a plan of treatment that includes goals, objectives and treatment strategies.

1. Treatment plan reviews must be provided by a team which includes at a minimum, one of the following: a Mississippi licensed Physician who holds a specialty in psychiatry, a Mississippi licensed Physician with five (5) years experience in mental health, a Mississippi licensed Psychologist, a Mississippi Licensed Certified Social Worker (LCSW), a Mississippi Licensed Professional Counselor (LPC), a Mississippi Licensed Marriage and Family Therapist (LMFT), a Psychiatric Mental Health Nurse Practitioner under an approved protocol, or a Physician Assistant.
2. Treatment plan reviews are limited to four (4) per state fiscal year.

D. Documentation requirements for Treatment Planning

1. The case record must contain documentation of an initial treatment plan developed and reviewed by the treatment team within thirty (30) days of completion of the biopsychosocial assessment, and subsequent reviews as individual case circumstances require, and at least annually. The more frequently any case is reviewed; the documentation must be stronger in the case record justifying the frequency of review.
2. The treatment plan form must be present in the case record and must include, at a minimum:
 - a) A multi-axial diagnosis (all five (5) axes addressed).
 - b) Identification of the beneficiaries and/or family's strengths.
 - c) Identification of the clinical problems or areas of need which are to be the focus of treatment.
 - d) Treatment goals for each identified need.
 - e) Treatment objectives that represent incremental progress towards goals, coupled with target dates for their achievement.
 - f) Specific services, objectives and activities that will be employed to reach each objective.
 - g) Date of implementation and signatures of the provider and beneficiary.
 - h) The date of the treatment plan review meeting.
 - i) The length of time spent in reviewing/planning treatment for the beneficiary.
 - j) A written report of treatment recommendations/changes resulting from the meeting.
 - k) The signature of each staff member present when the case was reviewed.

- 1) Length of meeting time that exceeds one (1) service unit per case must be clearly justified in the case record.
3. Initial treatment plan and all subsequent treatment plans must be reviewed by treatment team and recommendations clearly documented.

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

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

Rule 1.3 Psychotherapeutic Services

- A. Psychotherapeutic services are defined as intentional, face-to-face interactions (conversations or non-verbal encounters, such as play therapy) between a mental health therapist and a beneficiary (an individual, family or group) where a therapeutic relationship is established to help resolve symptoms of the beneficiary's mental and/or emotional disturbance.
- B. Individual Therapy is defined as one-on-one psychotherapy that takes place between a mental health therapist and a beneficiary. Individual therapy is limited to thirty-six (36) sessions per state fiscal year.
- C. Family Therapy is defined as psychotherapy that takes place between a mental health therapist and a beneficiary's family members, with or without the presence of the beneficiary. Family therapy may also include others (Department of Human Services (DHS) staff, foster family members, etc.) with whom the beneficiary lives or has a family-like relationship. This service includes family psychotherapy, psychoeducation, and family-to-family training. Family therapy is limited to twenty four (24) sessions per state fiscal year.
- D. Group Therapy is defined as psychotherapy that takes place between a mental health therapist and at least two (2) but no more than ten (10) children or at least two (2) but no more than twelve (12) adults at the same time. Possibilities include, but are not limited to, groups that focus on relaxation training, anger management and/or conflict resolution, social skills training, and self-esteem enhancement.
 1. Group therapy is not eligible for Medicaid reimbursement on the same day as any psychosocial rehabilitation service, day support, day treatment service, acute partial hospitalization or crisis residential.
 2. Group therapy is limited to forty (40) sessions per state fiscal year.
- E. Multi-Family Group Therapy is defined as psychotherapy that takes place between a mental health therapist and family members of at least two (2) different beneficiaries, with or without the presence of the beneficiary, directed toward the reduction/resolution of identified mental health problems so that the beneficiaries and/or their families may function more independently and competently in daily life. This service includes psychoeducational and

family-to-family training. Multi-family therapy is limited to forty (40) sessions per state fiscal year and that limit includes group therapy and multi-family group therapy.

F. Provider Requirements

1. All services under this category must be provided by a staff member who holds a master's degree and professional license (ex.: Physician, Psychologist, Licensed Certified Social Worker, Licensed Master Social Worker, Licensed Professional Counselor or Licensed Marriage & Family Therapist) or who is a DMH Certified Mental Health Therapist, DMH Certified Intellectual and Developmental Disabilities Therapist or a DMH Certified Addiction Therapist (when appropriate for the individual receiving service and the service provided).
2. Those who are provisionally certified must be supervised by a licensed professional or a
3. If evidence-based practices (EBP) or evidence-informed best practices such as Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) are employed in the course of treatment, they must be provided by a Master's degree therapist who holds a professional license or DMH certification and has completed appropriate training in that evidence-based practice.

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

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

Rule 1.4 Day Programs

- A. Psychosocial Rehabilitation is an active treatment program designed to support and restore community functioning and well-being of an adult Medicaid beneficiary who has been diagnosed with a serious and persistent mental disorder. Psychosocial rehabilitation programs must use systematic, curriculum based interventions for skills development for participants. Its purpose is to promote recovery in the individual's community by alleviating psychiatric decompensation, confusion, anxiety, feelings of low self-worth, isolation and withdrawal. Program activities aim to improve reality orientation, social adaptation, physical coordination, daily living skills, coping skills, effective management of time and resources, task completion and activities to incorporate the individual into independent community living. It is oriented toward empowerment, recovery and competency.
1. Psychosocial Rehabilitation may be provided to adults with a serious and persistent mental illness.
 2. Psychosocial Rehabilitation must be provided in a program certified by the Department of Mental Health.

3. Psychosocial Rehabilitation is the most intensive day program available for adults. It is designed to support individuals who require extensive clinical services to support community inclusion and prevent re-hospitalization.
4. Psychosocial Rehabilitation must be provided by a program which has at least one (1) clinical staff member present during the time of program operation.
 - a) Clinical staff member is defined as a staff member who holds a master's degree and professional license (ex.: Physician, Psychologist, Licensed Certified Social Worker, Licensed Master Social Worker, Licensed Professional Counselor or Licensed Marriage & Family Therapist) or who is a DMH Certified Mental Health Therapist, DMH Certified Intellectual and Developmental Disabilities Therapist or a DMH Certified Addiction Therapist (when appropriate for the individual receiving service and the service provided).
 - b) Those who are provisionally certified must be supervised by a licensed professional or a credentialed DMH Certified Mental Health Therapist, DMH Certified Intellectual and Development Disabilities Therapist or DMH Certified Addiction Therapist. The supervisor must be of the same discipline as those they supervise.
5. Beneficiaries may participate in psychosocial rehabilitation up to five (5) hours per day, up to five (5) days per week.
6. Psychosocial Rehabilitation services must be prior authorized by the Division of Medicaid or its designee, effective for dates of service on or after July 1, 2012.
7. Psychosocial Rehabilitation services are not eligible for Medicaid reimbursement on the same day as group therapy, day support, senior psychosocial rehabilitation, crisis residential or acute partial hospitalization.
8. Documentation Requirements - The case record must contain a monthly progress summary for each beneficiary that includes:
 - a) Notation of each date the service was provided,
 - b) The length of time the service was provided on each date, and
 - c) A summary of the beneficiary's progress that relates to the goals and objectives established on the Treatment Plan.

B. Reserved.

C. Senior Psychosocial Rehabilitation is a program of structured activities designed to support and enhance the ability of senior Medicaid beneficiaries to function at the highest possible level of independence in the most integrated setting appropriate to their needs. The activities target the specific needs and concerns of the senior while aiming to improve beneficiaries'

reality orientation, social adaptation, physical coordination, daily living skills, time and resource management, task completion and other areas of competence that promote independence in daily life. Activities are designed to alleviate such psychiatric symptoms as confusion, anxiety, disorientation, distraction, preoccupation, isolation, withdrawal and feelings of low self-worth.

1. Beneficiaries may participate in Senior Psychosocial Rehabilitation for a maximum of five (5) hours per day, a maximum of five (5) days per week.
2. Senior Psychosocial Rehabilitation may be provided to adults age fifty (50) and older with a diagnosis of a serious and persistent mental illness. It may be provided to individuals with intellectual and developmental disabilities through June 30, 2012.
3. Senior Psychosocial Rehabilitation must be provided by a program which has at least one clinical staff member present during the time of program operation.
 - a) Clinical staff member is defined as a staff member who holds a master's degree and professional license (ex.: Physician, Psychologist, Licensed Certified Social Worker, Licensed Master Social Worker, Licensed Professional Counselor or Licensed Marriage & Family Therapist) or who is a DMH Certified Mental Health Therapist, DMH Certified Intellectual and Developmental Disabilities Therapist or a DMH Certified Addiction Therapist (when appropriate for the individual receiving service and the service provided).
 - b) Those who are provisionally certified must be supervised by a licensed professional or a credentialed DMH Certified Mental Health Therapist, DMH Certified Intellectual and Development Disabilities Therapist or DMH Certified Addiction Therapist. The supervisor must be of the same discipline as those they supervise.
4. Senior Psychosocial Rehabilitation services provided in a nursing facility must also be authorized through the Preadmission Screening and Resident Review (PASRR) rules.
5. Senior psychosocial rehabilitation services provided in the community for individuals who are not residents of a nursing facility must be prior authorized by the Division of Medicaid or its designee for dates of service on or after July 1, 2012.
6. Elderly psychosocial services are not eligible for Medicaid reimbursement on the same day as group therapy, day support, psychosocial rehabilitation, crisis residential or acute partial hospitalization.
7. Documentation Requirements - The case record must contain a progress summary for each beneficiary that includes:
 - a) Notation of each date the service was provided,
 - b) The length of time the service was provided on each date, and

- c) A summary of the beneficiary's progress that relates to the goals and objectives established on the Treatment Plan.

D. Day Treatment is a behavioral intervention program, provided in the context of a therapeutic milieu, which provides primarily school age children/adolescents with serious emotional disturbances (SED) the intensity of treatment necessary to enable them to live in the community. The program is based on behavior management principles and includes, at a minimum, positive feedback, self-esteem building and social skills training. Additional components are determined by the needs of the participants in a particular program and may include skills training in the areas of impulse control, anger management, problem solving, and/or conflict resolution. The most important element of Day Treatment is the consistency and qualifications of the staff providing the service. Day Treatment is the most intensive outpatient program available to children and adolescents. It provides an alternative to residential treatment or acute psychiatric hospitalization and/or serves as a transition from these services.

1. Beneficiaries may participate in the program a maximum of five (5) hours per day, five (5) days per week with a minimum of four hours per week.
2. Day Treatment may be provided to children with SED.
3. No less than four (4) individuals may participate in a Day Treatment program in order to achieve a therapeutic milieu.
4. No Day Treatment room shall have more than ten (10) individuals with emotional and/or behavior disorders participating in the program at any time.

If programs are developed for individuals with a diagnosis of Autism/Asperger's are developed around youth who meet medical necessity criteria, there shall be no more than four (4) individuals with a diagnosis of Autism/Asperger's per program.

5. In order to participate in the Day Treatment program, a child or youth must be on the permanent roster for the program. They shall not participate on an intermittent basis.
6. Day Treatment must include involvement of the family or individuals acting in loco parentis as often as possible, but not less than twice per month, in order to achieve improvement that can be generalized across environments.
7. Day Treatment Services are not eligible for Medicaid reimbursement on the same day as group therapy, crisis residential or acute partial hospitalization.
8. Day Treatment must be prior authorized by the Division of Medicaid or its designee for dates of service on or after July 1, 2012.

9. Day Treatment services must be provided by a non-case management staff member who holds a Master's Degree and professional license (ex: Licensed Certified Social Worker, Licensed Marriage & Family Therapist, Licensed Professional Counselor, Psychologist, Licensed Master Social Worker, or a Medical Doctor) or who is a DMH Certified Mental Health Therapist or DMH Provisionally Certified Mental Health Therapist.

10. The staff person providing day treatment services must also provide other therapy services for the children and youth in day treatment, which are deemed medically necessary whenever possible.

11. Documentation Requirements

a) The case record must contain progress notes for each beneficiary.

b) The progress notes must include:

1) Date the service was provided,

2) Length of time the service was provided on each date, and

3) A summary of the beneficiary's progress that relates to the goals and objectives established on the Treatment Plan.

E. Acute Partial Hospitalization is a program that provides medical supervision, nursing services, structured therapeutic activities and intensive psychotherapy (individual, family and/or group) to beneficiaries who are experiencing a period of such acute distress that their ability to cope with normal life circumstances is severely impaired. Acute Partial Hospitalization is designed to provide an alternative to inpatient hospitalization for such beneficiaries or to serve as a bridge from inpatient to outpatient treatment. Program content may vary based on beneficiary need but must include close observation/supervision and intensive support with a focus on the reduction/elimination of acute symptoms.

1. Acute Partial Hospitalization may be provided to children with SED or adults with SPMI.

2. Acute Partial Hospitalization must be prior authorized by the Division of Medicaid or its designee for dates of service on or after July 1, 2012.

3. Acute Partial Hospitalization programs must be certified by the Department of Mental Health.

4. Acute Partial Hospitalization programs must have medical supervision and nursing services immediately available during hours of operation.

5. Acute Partial Hospitalization is limited to one hundred (100) days per state fiscal year.

6. Documentation requirements:

- a) The case record must contain a physician order for the service stating that inpatient care would be necessary without the service.
- b) The case record must contain a daily progress summary for each beneficiary which meets the documentation criteria for acute partial hospitalization services.

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

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

Rule 1.5 Crisis Services

A. Crisis Response Services

1. Crisis Response Services - Time limited intensive intervention, available twenty-four (24) hours a day, seven (7) days a week. Crisis response services allow for the assessment of the crisis and ability to activate a mobile crisis team. Trained crisis response staff provides crisis stabilization and treatment of a Medicaid eligible individual directed toward preventing hospitalization. Children or adults requiring crisis services are those who are experiencing a significant emotional/behavioral crisis. A crisis situation is defined as a situation in which an individual's mental health and/or behavioral health needs exceed the individual's resources, in the opinion of the mental health professional assessing the situation.
 - a) Crisis Response services are considered community based services and must be available face-to-face whenever the beneficiary and their family is in need of crisis response services. Initial crisis response may be provided by telephone.
 - b) Crisis Response services are available to adults exhibiting symptomology indicating a serious and persistent mental illness or children and youth exhibiting symptomology indicating a serious emotional disturbance.
 - c) Crisis Response services may be provided in the emergency department of a hospital.
 - d) Crisis Response services may be provided prior to an individual being "admitted" to services with a service provider. Individuals needing crisis services will not be required to have an "intake" or "biopsychosocial assessment" prior to receiving crisis services. They may be "admitted" to services secondary to a crisis response service.
2. Provider requirements
 - a) All services under this Rule must be provided by a staff member who holds a Master's degree and professional license (ex:, Physician, Psychologist, Licensed Certified Social Worker, Licensed Master Social Worker, Licensed Professional

Counselor or Licensed Marriage & Family Therapist) or who is a DMH Certified Mental Health Therapist.

The Division of Medicaid does not provide reimbursement for crisis response services provided by provisionally certified staff.

- b) Medical professionals must be available by phone to the staff member providing crisis response services including, at a minimum, a licensed registered nurse and psychiatry professional who is licensed as one of the following:
 - 1) Board-certified Psychiatrist, or
 - 2) Psychiatric mental health nurse practitioner, or
 - 3) Physician assistant with two (2) years' experience in the practice of psychiatry.
- c) All staff members providing crisis response services must obtain and maintain certification in a professionally recognized method of crisis intervention and de-escalation, such as Techniques for Managing Aggressive behavior, the Mandt system or Nonviolent Crisis Intervention.

3. Documentation requirements

Progress notes must clearly document that the crisis services provided are necessary to maintain the child or adult in the least restrictive and most appropriate, environment.

- B. Crisis Residential is a residential program that provides medical supervision, nursing services, structured therapeutic activities, and intensive psychotherapy (individual, family and/or group) at a facility based site. Services are provided to beneficiaries who are experiencing a period of such acute distress that their ability to cope with normal life circumstances is severely impaired. Crisis Residential is designed to prevent inpatient hospitalization, address acute symptoms, distress, and further decomposition, and also help transition from hospitalization to community based services. Program content may vary based on beneficiary need but must include close observation/supervision and intensive support with the focus on reduction/elimination of acute symptoms.
 - 1. Crisis residential may be provided to children or youth with serious emotional/behavioral disturbance or adults with a serious and persistent mental illness.
 - 2. Crisis residential must be ordered by a psychiatrist, psychiatric mental health nurse practitioner or licensed psychologist.
 - 3. Crisis residential must be prior authorized by the Division of Medicaid or its designee for dates of service on or after July 1, 2012.

4. Services must be provided at a facility licensed to service no more than sixteen (16) individuals at a time.
5. Medicaid reimbursement for crisis residential does not include room and board costs.
6. Crisis residential is limited to sixty (60) days per state fiscal year.
7. A psychiatrist, psychiatric mental health nurse practitioner or psychologist must be at the location of the crisis residential program and immediately available if needed.
8. Documentation Requirements
 - a) Medical services must be documented according to industry standard for medical hospitals.
 - b) Other clinical services must be documented according to the DMH Record Guide.

Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

Rule 1.6 Community Support Services

- A. Community Support Services (CSS) provides an array of support services delivered by community based mobile professionals. Services address the individualized mental health needs of the client. They are directed towards adults, children, adolescents and families and will vary with respect to hours, type and intensity of services, depending on the changing needs of each individual. The purpose/intent of CSS is to provide specific, measurable, and individualized services to each person served. CSS should be focused on the individual's ability to succeed in the community; to identify and access needed services; and to show improvement in school, work and family and integration and contributions within the community. This service replaces the direct services historically provided as case management in Mississippi.
1. Community Support Services are services that can be provided to/for the individual by the CSS Specialist in any setting within the community absent from being involved in any other Medicaid reimbursable service simultaneously. The CSS Specialist not only assists the individual in gaining access to needed services necessary for community integration and sustainability within the community, but may also provide some of those direct services themselves, such as supportive counseling/reality orientation, skills training, enlisting social supports, financial management counseling, monitoring physical and mental health status, etc.
 - a) Community support services are defined as services that are specific, measurable, and individualized that focus on the individual's ability to succeed in the community; to identify and access needed services; and to show improvement in school, work, and

family and integration and contributions within the community. These shall include the following as clinically indicated:

- 1) Identification of strengths which will aid the individual in their recovery and the barriers that will challenge the development of skills necessary for independent functioning in the community.
 - 2) Individual therapeutic interventions with a beneficiary that directly increase the acquisition of skills needed to accomplish the goals set forth in the Individual Service Plan.
 - 3) Monitoring and evaluating the effectiveness of interventions, as evidenced by symptom reduction and program toward goals.
 - 4) Psychoeducation on the identification and self-management of prescribed medication regimen and communication with the prescribing provider.
 - 5) Direct interventions in deescalating situations to prevent crisis.
 - 6) Assisting the beneficiary and natural supports in implementation of therapeutic interventions outlined in the Individual Service Plan.
 - 7) Relapse prevention and disease management strategies.
 - 8) Psychoeducation and training of family, unpaid caregivers, and/or others who have a legitimate role in addressing the needs of the individual.
 - 9) Facilitation of the Individual Service Plan which includes the active involvement of the beneficiary and the people identified as important in the person's life.
2. Community support services are limited to four hundred (400) units (15 minute unit) per state fiscal year and six (6) per day.
3. Provider requirements
- a) Community Support Services must each be provided by a staff member who holds a minimum of at least a Bachelor's Degree in mental health.
 - b) The provider of this service must be provisionally certified by the DMH as a Certified Community Support Specialist within six (6) months of their hire date. The professional who provides these services will be known as the Community Support Specialist (CSS). The DMH certification for Case Management Professionals will be accepted for dates of service prior to January 1, 2013.
 - c) Supervision for services under this Rule must be provided by a staff member who holds a Master's degree and professional license (ex:, Physician, Psychologist,

Licensed Certified Social Worker, Licensed Master Social Worker, Licensed Professional Counselor or Licensed Marriage & Family Therapist) or who is a DMH Certified Mental Health Therapist, or a DMH Certified Addiction Therapist (when appropriate for the individual receiving service and the service provided). Supervision may not be provided by a staff member who is provisionally certified.

4. Documentation Requirements

Progress notes must clearly document that the Community Support Services provided are medically necessary to maintain the child or adult in the least restrictive, yet appropriate environment within the community and must relate back to the treatment plan/service plan.

Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

Rule 1.7 Peer Support Services

A. Peer Support Services are person-centered services with a rehabilitation and recovery focus designed to promote skills for coping with and managing psychiatric symptoms while facilitating the utilization of natural resources and the enhancement of community living skills. Peer Support Service is a helping relationship between peers and/or family member(s) that are directed toward the achievement of specific goals defined by the consumer. It may also be provided as a family partner role.

1. Peer Support Services are face-to-face interventions with the consumer or family present.
2. Provider Requirements
 - a) Services must be rendered by a peer specialist certified by the Department of Mental Health using a certified curriculum.
 - b) Peer support specialists must receive annual training in a recognized peer training program recognized by DMH.
 - c) Peer support specialists must possess a high school diploma or GED equivalent. For young adults ages sixteen to twenty (16-20) years, peer support specialists must be enrolled and attending school or in the process of obtaining a Test of General Education Development (GED).
 - d) Peer support specialists must be a current or former consumer/first degree family member of an individual who has received treatment for and self-identify as a current or former mental health consumer and/or family member.
 - e) Staff must have completed an appropriate training program, such as family-to-family or Family Time Out.

- f) Peer support specialists will have, during the last year, demonstrated a minimum of six (6) months in self-directed recovery.
- g) Peer support services are limited to two hundred (200) units (15 minute unit) per state fiscal year.
- h) Peer support services must be supervised by a Peer Support Services Supervisor with a minimum of a Master's degree and who has received basic Peer Specialist training specifically developed for supervision within the Peer Specialist program, as provided by DMH.

3. Documentation Requirements

Peer Support Services must be included in and coordinated with the individual's treatment plan with a specific planned frequency for patients who the physician and/or mental health professional believes would benefit from this recovery support process.

Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

Rule 1.8 Wraparound Facilitation

A. Wraparound Facilitation is the creation and facilitation of a child and family team for the purpose of developing a single plan of care to address the needs of youth with complex mental health challenges and their families. The child and family team will meet regularly to monitor and adjust the plan of care if necessary or progress is not being made. Wraparound facilitation is intended to serve individuals who have serious mental health challenges that exceed the resources of a single agency or service provider, experienced multiple acute hospital stays, at risk of out-of-home placement or have been recommended for residential care or have had interruptions in the delivery of services across a variety of agencies due to frequent moves, failure to show improvement, lack of previous coordination by agencies providing care, or reasons unknown.

Wraparound facilitation must be provided in accordance with high fidelity and quality wraparound practice.

1. Services are comprised of a variety of specific tasks and activities designed to carry out the wraparound process, including:
 - a) Engaging the family,
 - b) Assembling the child and family team,
 - c) Facilitating a child and family team meeting at minimum every thirty (30) days,

- d) Facilitating the creation of a plan of care, which includes a plan for anticipating, preventing and managing crisis, within the child and family team meeting,
 - e) Working with the team in identifying providers of services and other community resources to meet family and youth needs,
 - f) Making necessary referrals for youth,
 - g) Documenting and maintaining all information regarding the plan of care, including revisions and child and family team meetings,
 - h) Presenting plan of care for approval,
 - i) Providing copies of the plan of care to the entire team including the youth and family/guardian,
 - j) Monitoring the implementation of the plan of care and revising if necessary to achieve outcomes,
 - k) Maintaining communication between all child and family team members,
 - l) Monitoring the progress toward need met and are the referral behaviors decreasing,
 - m) Leading the team to discuss and ensure the supports and services the youth and family are receiving continue to meet the caregiver and youth's needs,
 - n) Educating new team members about the wraparound process, and
 - o) Maintaining team cohesiveness.
2. Child and family team membership must include:
- a) The wraparound facilitator,
 - b) The child's service providers, any involved child serving agency representatives and other formal supports, as appropriate,
 - c) The caregiver/guardian,
 - d) Other family or community members serving as informal supports, as appropriate, and
 - e) Identified youth, if age nine (9) or above, unless there are clear clinical indications this would be detrimental. Such reasons must be documented clearly throughout the record.

3. Wraparound facilitation is limited to one hundred (100) units (15 minute unit) per state fiscal year and eight (8) units per day.
4. Provider requirements
 - a) Wraparound facilitators and supervisors of the process must have completed Introduction to Wraparound 3-day training.
 - b) Wraparound facilitators and supervisors must participate in ongoing coaching and training as defined by the Division of Medicaid.
 - c) The provider organization or CMHC providing Wraparound facilitation must be participating in the wraparound certification process through the Division of Medicaid or its designee.
 - d) Providers must ensure case load size for wraparound facilitators is maintained at an average of not more than ten (10) cases per wraparound facilitator.

Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

Rule 1.9 Medical Services

A. Medication Evaluation & Monitoring

1. Medication Evaluation & Monitoring is the intentional face-to-face interaction (including telehealth transmissions) between a physician, physician assistant, or a nurse practitioner and a beneficiary for the purpose of:
 - a) Assessing the need for psychotropic medication,
 - b) Prescribing medications, and
 - c) Regular periodic monitoring of the medications prescribed for therapeutic effect and medical safety.
2. Medication Evaluation & Monitoring Services must be provided by a:
 - a) Licensed physician,
 - b) Doctor of osteopathy,
 - c) Psychiatric mental health nurse practitioner, or
 - d) Physician assistant with two (2) years psychiatric training

3. Medical monitoring of psychotropic medications must include lab testing for medical side effects as recommended in package insert and as is the standard of care.
4. Medication evaluation & management may be provided by the use of telehealth.
5. Medication evaluation & management is limited to a total of seventy-two (72) services per state fiscal year when combined with the psychiatric interview and therapy with medication management.

6. Documentation Requirements

Medication(s) prescribed must be documented on the Medication Profile sheet in the case record.

B. Nursing Assessment

1. Nursing Assessment takes place between a registered nurse and a beneficiary for the purpose of assessing extra-pyramidal symptoms, medication history, medical history, progress on medication, current symptoms, progress or lack thereof since last contact and providing education to the beneficiary and the family about the illness and the course of available treatment.
2. Nursing assessment is limited to one hundred forty-four (144) units (15 minute units) per state fiscal year and four (4) units per day.
3. Provider requirements
 - a) Nursing Assessment must be provided by, at a minimum, a registered nurse.
 - b) A physician, doctor of osteopathy, nurse practitioner, physician assistant, and psychiatric mental health nurse practitioner are also eligible providers.
4. Current medication(s) must be documented on the Medication Profile sheet in the case record.

C. Injectable medication is provided in a physician's office or community mental health center for the purpose of restoring, maintaining or improving the beneficiary's role performance and/or mental health status.

1. Mississippi Medicaid provides coverage for injectable drugs when they are administered in a clinically appropriate manner. If a portion of the drug in a single use or multiple dose use vial must be discarded, DOM will not reimburse for the discarded amount of the drug.
2. Providers may not bill Mississippi Medicaid beneficiaries for the discarded drug.

3. Injections shall be administered by a licensed physician, psychiatric mental health nurse practitioner, physician assistant, registered nurse or licensed practical nurse.
4. Documentation Requirements
 - a) The case record must contain a specific physician's order for the service.
 - b) The case record must contain documentation of the following:
 - 1) The date of each injection,
 - 2) The name of the medication,
 - 3) The dosage, and
 - 4) The site of injection.
5. The documentation must be authenticated by the signature and credentials of the person who gave the injection.

Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

Rule 1.10 Program of Assertive Community Treatment

A. Assertive Community Treatment

Assertive Community Treatment (ACT/PACT) is a multi-disciplinary, self-contained clinical team approach providing comprehensive mental health and rehabilitative services. Team members provide long-term intensive care in natural community settings. The team provides all mental health services rather than referring individuals to different mental health providers, programs, and other agencies. Major activities under ACT/PACT may include: client specific treatment team planning – team meets daily to plan services, assesses individuals community status and share information to coordinate services; individual supports – for activities of daily living, financial management, skills training, medication support; coordination with collaterals – sharing information with healthcare and other providers; individual clinical interventions – therapy, diagnosis and assessment.

1. Program of Assertive Community Treatment (PACT) is defined as therapeutic programs provided in the community in which individuals live that would traditionally need inpatient care and treatment can be maintained in a less restrictive/community based setting.
2. The aim of PACT is to address the varied needs of adults with serious and persistent mental illness in a mobile treatment team approach/ environment.

3. PACT services include a self-contained treatment milieu based on the level of need of the individual.
4. PACT services allow concurrent service provision by more than one PACT staff member when clinically indicated and substantiated in the documentation.
5. PACT services are limited to sixteen hundred (1600) units (15 minute unit) per state fiscal year and forty (40) units per day.
6. PACT services must be prior authorized by the Division of Medicaid or its designee, for dates of service on or after July 1, 2012.
7. Services include:
 - a) Psychiatric service/assessment/treatment (including telepsychiatry);
 - b) Nursing;
 - c) Peer support;
 - d) Medication monitoring/evaluation;
 - e) Vocational;
 - f) Transportation;
 - g) Housing;
 - h) Employment services; and
 - i) Administrative case management.
8. Provider requirements
 - a) ACT/PACT Teams must be certified by the Department of Mental Health and maintain all standards set forth by the Department of Mental Health.
 - b) ACT/PACT Services must be provided by staff members who are certified/qualified/credentialed/ licensed to provide the service required.
9. Non-covered services
 - a) Beneficiaries enrolled in ACT/PACT programs cannot receive community based mental health services from any provider other than an ACT/PACT provider.

- b) Beneficiaries enrolled in ACT/PACT may not receive psychosocial rehabilitation, senior psychosocial rehabilitation, or day support.

10. Documentation Requirements

- a) All documentation must meet the requirements set forth by the DMH minimum standards.
- b) The case record must also contain:
 - 1) A daily progress summary for each beneficiary which meets the documentation criteria for PACT daily total of time spent with the beneficiary.
 - 2) The case record must contain a physician's order for the service stating that inpatient care would be necessary without the service.
 - 3) A written report of treatment recommendations/changes resulting from a treatment plan review and the signature of each staff present when the case was reviewed.

Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

Rule 1.11 Intensive Outpatient Psychiatric

A. Intensive Outpatient Psychiatric (IOP) services are:

1. An all-inclusive, psychiatric clinical suite of multifaceted services acting as a wrap-around to families with children/youth with serious emotional disturbances (SED) for family stabilization in the home and community.
2. To diffuse the current crisis, stabilize the living arrangement and offer the family and children/youth alternatives to being in crisis.
3. To safely intervene with families that request treatment but cannot commit to the intensity of MYPAC services in their home and:
 - a) Can safely manage the crisis with clinical professional services and support two (2) to four (4) hours, three (3) to five (5) days per week,
 - b) Have sufficiently stabilized following ninety (90) days of MYPAC services and request or choose less intensive interventions than MYPAC to safely address and stabilize,
 - c) Have children/youth discharging from PRTF care greater than one hundred eighty (180) days, and/or

- d) Have children/youth with greater than one (1) acute inpatient admission in the past six (6) months.

B. To receive IOP services a beneficiary must have:

1. A primary focus of symptoms and diagnosis related to the primary psychiatric disorder as defined in the most recent Diagnostic and Statistical Manual (DSM) and symptoms which require rehabilitative services,
2. An evaluating psychiatrist or licensed psychologist advising that the beneficiary needs IOP services,
3. The need for specialized services and supports from multiple agencies including targeted case management and an array of clinical interventions and family supports,
4. A BioPsychoSocial assessment addressing safety in the community, cultural and spiritual aspects of the family within six (6) months of the anticipated admission date if admitted from the community or less intensive outpatient services, and
5. A discharge summary with a recommendation for IOP services if admitted from an inpatient setting.

C. Providers of IOP services must:

1. Hold certification by Department of Mental Health (DMH) to provide case management/community support services,
2. Have a psychiatrist on staff,
3. Have appropriate clinical staff to provide therapy services needed,
4. Inform the Division of Medicaid in writing of any critical incidents (life-threatening, allegations of staff misconduct, abuse/neglect) and describe staff management of the incident,
5. Inform the beneficiary/family of grievance and appeals procedures,
6. Report all grievances and appeals to the Division of Medicaid,
7. Have staff who meet the Division of Medicaid's qualifications for the category of service they provide,
8. Be a qualified provider of wrap-around facilitation, and

9. Have procedures in place for availability and response twenty-four (24) hours a day, seven (7) days a week.

D. IOP services:

1. Require prior authorization by the Utilization Management/Quality Improvement Organization (UM/QIO),
2. Are limited to two hundred seventy (270) days of service provision per state fiscal year,
3. Are only reimbursed for the date a service is provided, and
4. Component parts cannot be separately reimbursed on the same day as the all-inclusive IOP service.

E. Each beneficiary receiving IOP services must have on file:

1. An individualized service 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 support available to the participant and family, and
 - e) Plan for anticipating, preventing and managing crises.
2. A BioPsychoSocial Assessment which must address:
 - a) The family system,
 - b) Identify the primary caretaker(s) and supports, and
 - c) Identify both the beneficiary's and primary caretaker's functional adaptability for learning and retaining cognitive, behavioral and other therapeutic techniques.

Source: SPA 2012-003, Miss. Code §§ 43-13-117, 43-13-121.

History: Revised eff. 01/01/2014.

Rule 1.12 Treatment Foster Care

- A. Treatment Foster Care (TFC) services are intensive and supportive services provided to children in Department of Human Services (DHS) custody or at-risk of having DHS obtain

custody with significant medical, developmental, emotional, or behavioral needs, who with additional resources, can remain in a family setting and achieve positive growth and development. Service includes specialized training, clinical support, and in-home intervention to treatment foster parents and the child, allowing the child to remain in a family home setting. Payment for TFC services are not inclusive of room and board payment.

1. Treatment Foster Care is an intensive community-based program composed of mental health professional staff and trained foster parents who provide a therapeutic program for children and youth with serious emotional disturbances living in a licensed therapeutic foster home.
 2. Treatment foster care must be approved by the Department of Human Services
 3. Treatment Foster Care must be prior authorized by the Division of Medicaid or its designee.
 4. Treatment Foster Care is limited to three hundred sixty five (365) days per state fiscal year.
 5. Each licensed TFC home must not have more than (1) child or youth with SED at any given time. Siblings with SED may be placed together in the same TFC home.
 6. Provider requirements
 - a) Treatment foster care programs must be certified by the Department of Mental Health.
 - b) Provider must have available a licensed psychiatrist with experience working with children/youth.
 - c) All clinical services must be provided by a staff member who holds a Master's degree and professional license (ex.: Physician, Psychologist, Licensed Certified Social Worker, Licensed Master Social Worker, Licensed Professional Counselor or Licensed Marriage & Family Therapist) or who is a DMH Certified Mental Health Therapist, DMH Certified Intellectual and Developmental Disabilities Therapist or a DMH Certified Addiction Therapist (when appropriate for the individual receiving service and the service provided).
- B. TFC programs must provide mental health services for all children in the program in the following manner and those services are included in the TFC service:
1. Individual therapy one (1) session per week with child/youth,
 2. A minimum of two (2) family sessions per month with the therapeutic foster parents,

3. Face-to-face contact with TFC parents at least two (2) times a month, with at least one (1) of the two (2) contacts in the home,
4. TFC support groups once a month,
5. Annual psychiatric evaluation, and
6. Twenty four (24) hour per day and seven (7) days a week emergency services and crisis intervention.

C. Non-covered services

Providers of Treatment Foster Care Services shall not bill Medicaid separately for the component parts of Treatment Foster care listed in 2.4.B of this rule.

Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

Rule 1.13 Multi-Systemic Therapy

A. Multi-systemic therapy (MST) for youth in the juvenile justice system is an evidence-based practice of a strengths intensive family-and community-based treatment program that focuses on the entire world of chronic juvenile offenders — their homes and families, schools and teachers, neighborhoods and friends. MST interventions work to increase the caregivers' parenting skills, improve family relations, involve the youth with friends who do not participate in criminal behavior, help him or her get better grades or start to develop a vocation, help the adolescent participate in positive activities, such as sports or school clubs, create a support network of extended family, neighbors and friends to help the caregivers maintain the changes.

1. MST Services include:

- a) An initial assessment to identify the focus of the MST intervention,
- b) Individual therapeutic interventions with the youth and family,
- c) Peer interventions,
- d) Case management,
- e) Crisis stabilization, and
- f) Specialized therapeutic interventions to address areas such as substance abuse, sexual abuse, sex offending, and domestic violence, when needed.

2. Services must be available in-home, at school and in other community settings

3. MST services are delivered in a team approach designed to address the identified needs of children and adolescents with significant behavioral problems who are transitioning from out of home placements or are at-risk of out-of-home placement and need intensive interventions to remain stable in the community.
4. MST services must be ordered by a physician, licensed psychologist, physician's assistant or nurse practitioner.
5. MST services allows for collateral contacts and phone contact.
6. MST services must be prior authorized by the Division of Medicaid or its designee.
7. MST services are limited to three hundred twelve (312) units (15 minute unit) per state fiscal year and eight (8) units per day.
8. Provider qualifications:
 - a) MST services must be delivered by practitioners employed by an agency.
 - b) Within three (3) years of enrollment as a provider, the agency must have achieved national accreditation in MST.
 - c) Providers must have the availability of crisis response on a twenty-four (24) hours a day, seven (7) days a week.
 - d) Staff providing MST services must participate in MST introductory training and ongoing training and consultation as required by the Division of Medicaid.
 - e) The MST program must have a team supervisor who is a Master's level or above professional or has a minimum at least two (2) years of experience in mental health or child welfare services.
 - f) MST Therapists must be full-time, MST dedicated Masters-level staff.
 - g) MST team member to family ration shall not exceed a one (1) to five (6) ratio.

Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

Rule 1.14 Targeted Case Management

- A. Targeted Case Management is defined as services that provide information/referral and resource coordination to the beneficiary and/or his/her collaterals. Case Management Services are directed towards helping the beneficiary maintain his/her highest possible level of independent functioning. Case managers monitor the treatment plan and ensure team

members complete tasks that are assigned to them, that follow up and follow through occur and help identify when the treatment team may need to review the treatment plan for updates if the established plan is not working.

1. Targeted case management may be provided face-to-face or via telephone.
 - a) Targeted case management is not designed to be a mobile service, but there is no prohibition on services being provided in a location other than the community mental health center.
 - b) If services are provided at another location, travel time is not a covered service.
2. Targeted case management must be provided by, at a minimum, a licensed social worker (LSW) with two (2) years' experience in mental health or a registered nurse (RN) with two (2) years' experience in mental health.
3. Targeted case management must be included in the individual's treatment plan.
4. The frequency of case management services will be determined by the complexity of the case and the need of the beneficiary, but shall not occur less than once monthly.
5. Targeted case management services are limited to two hundred sixty (260) units (15 minute unit) per state fiscal year.

Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

Rule 1.15 School Based Services

- A. School Based Services are covered by the Division of Medicaid for dates of service through June 30, 2012. As of July 1, 2012, School-based services as defined in this rule will no longer be covered by Medicaid. Mental health services provided in the school setting will be covered as Community Support Services or other therapy services, as appropriate based on the individual need.
- B. School-based services are professional therapeutic services provided in a school setting that is more intensive than traditional case management services. School based services include consultation and crisis intervention. School-Based Services may be provided to SED and MR/DD children.
 1. Consultation is professional advice and support provided by a therapist to a child's teachers, guidance counselors, and other school professionals, as well as to parents, community support providers, treatment teams, court systems, etc. Consultation may be provided as a form of early intervention when no formal treatment process has been established. Parent and/or teacher conferences are included in this service component.

2. Crisis Intervention is therapeutic engagement at a time of internal or external turmoil in a child's life with a focus on producing effective coping. Crisis intervention strategies may be directed toward alleviating immediate personal distress, assessing the precipitants that produced the crisis, and /or developing preventative strategies to reduce the likelihood of future similar crises. This service may be provided to family members when their involvement relates directly to the identified needs of the child.
3. All services under this category must be provided by a staff member who holds a master's degree and professional license (ex.: Physician, Psychologist, Licensed Certified Social Worker, Licensed Master Social Worker, Licensed Professional Counselor or Licensed Marriage & Family Therapist) or who is a DMH Certified or Provisionally Certified Mental Health Therapist, DMH Certified or Provisionally Certified Intellectual and Developmental Disabilities Therapist or a DMH Certified or Provisionally Certified Addiction Therapist (when appropriate for the individual receiving service and the service provided).

Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

Rule 1.16 Mental Illness Management Services

- A. Mental Illness Management Services are covered by the Division of Medicaid for dates of service through June 30, 2012. As of July 1, 2012, Mental Illness Management Services as defined in this rule will no longer be covered by Medicaid. Mental health services for individuals having more complex mental health needs will be covered as Assertive Community Treatment, Community Support Services or other therapy services, as appropriate based on the individual need.
- B. Mental Illness Management Services (MIMS) are intensive case management services with a therapeutic focus. Activities may include symptom evaluation/monitoring, crisis intervention, provision/enhancement of environmental supports, and other services directed towards helping the beneficiary live successfully in the community. MIMS are distinguished from traditional case management services by the higher level of professional expertise/skill of the provider, required by the more complex mental health needs of the beneficiary, of these services. MIMS may be provided in any appropriate community setting. MIMS may be provided to SED and MR/DD children or SPMI and MR/DD adults.
- C. All services under this category must be provided by a staff member who holds a master's degree and professional license (ex.: Physician, Psychologist, Licensed Certified Social Worker, Licensed Master Social Worker, Licensed Professional Counselor or Licensed Marriage & Family Therapist) or who is a DMH Certified or Provisionally Certified Mental Health Therapist, DMH Certified or Provisionally Certified Intellectual and Developmental Disabilities Therapist or a DMH Certified or Provisionally Certified Addiction Therapist (when appropriate for the individual receiving service and the service provided).

Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

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

Rule 2.1: Purpose

- A. The purpose of Mississippi Youth Programs Around the Clock (MYPAC) services is to provide home and community-based services to beneficiaries up to the age of twenty-one (21) with serious emotional disturbance (SED) that:
1. Exceed the resources of a single agency or service provider,
 2. Experience multiple acute hospital stays,
 3. Have been recommended for residential care,
 4. Have had interruptions in the delivery of services across a variety of agencies due to frequent moves, failure to show improvement, lack of previous coordination by agencies providing care, or reasons unknown,
 5. Are at immediate risk of requiring treatment in a Psychiatric Residential Treatment Facility (PRTF), or
 6. Are receiving services in a PRTF and are ready to transition back to the community.
- B. The Division of Medicaid defines MYPAC services as all-inclusive home and community based services that assist beneficiaries and their families in gaining access to needed mental health services as well as medical, social, educational and other services regardless of the funding source for those other services and includes service coordination that involves finding and organizing multiple treatment and support services.

Source: Miss. Code Ann. §§ 43-13-117(46), 43-13-121, 43-14-1; Public Law 99-660 (1986), 101-639 (1990), 102-321 (1992); OBRA Section 4755.

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

Rule 2.2: Eligibility

- A. Beneficiaries must meet clinical and age criteria to receive MYPAC services.
1. The Utilization Management and Quality Improvement Organization (UM/QIO) for the Division of Medicaid reviews and prior authorizes the provision of services based on all the following clinical criteria. A beneficiary:

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

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

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

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

Rule 2.3: Provider Participation Requirements

- A. Providers of MYPAC services must satisfy all requirements set forth in Part 200, Chapter 4, Rule 4.8.
- B. MYPAC service providers must also meet the following provider specific requirements:
 - 1. Submit a completed proposal package and enter into a provider agreement with the Division of Medicaid to provide services under the State Plan Rehabilitation Option Intensive Outpatient Psychiatric Services.
 - 2. Provide MYPAC services by mental health providers who meet the Mississippi Department of Mental Health (DMH) certification requirements.
 - 3. Have a current Medicaid provider number.
 - 4. Hold certification by DMH to provide:
 - a) Case management services under the 1915(c) demonstration waiver, or

- b) Wraparound facilitation services under the State Plan Rehabilitation Option Intensive Outpatient Psychiatric Services.
5. Have a psychiatrist on staff.
6. Have appropriate clinical staff to provide needed therapy services.
7. Provide the Division of Medicaid with a written description of any critical incidents as well as staff interventions, responses and management of the critical incident. A critical incident is an occurrence or situation that creates a significant risk or serious harm to the physical or mental health, safety or well-being of a beneficiary including, but not limited to life-threatening events, allegations of staff misconduct, or abuse/neglect.
8. Inform the beneficiary/family of grievances and appeals procedures.
9. Report all grievances and appeals to the Division of Medicaid.
10. Employ staff who meets the Division of Medicaid qualifications for the category of service they provide.
11. Conduct Quality Assurance activities to regularly review each beneficiary's Individualized Service Plan (ISP) and treatment outcomes.
12. Have procedures in place for availability and response twenty-four (24) hours a day, seven (7) days a week.
13. Notify the Division of Medicaid of changes in the Administrative/Program Director, Medical Director/Psychiatrist or Clinical Director, and Regional Supervisor within seventy-two (72) hours of the effective change.

Source: Miss. Code Ann. §§ 43-13-117, 43-13-118, 43-13-121, 43-13-129; 42 CFR §§ 441, Subpart D, 441.151(a)(2).

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

Rule 2.4: MYPAC Service Requirements

- A. The Division of Medicaid covers one hundred fifteen (115) units during a three hundred and sixty-five (365) day period of MYPAC services.
- B. MYPAC services include, but are not limited to:
 1. Mental health services using evidence-based practices which include intensive in-home therapy, crisis outreach, medication management and psychiatric services,

2. Social services to ensure basic needs are met, provide family support, and develop age appropriate independent living skills.
 3. Physical health and welfare services that include assistance to the family in obtaining screenings from the Early Periodic Screening, Diagnosis, and treatment (EPSDT) services.
 4. Educational and/or vocational services to assist with school performance and/or provide support for employment,
 5. Recreational activities to identify skills and talents, enhance self-esteem, and increase opportunities for socialization, and
 6. Other supports and services as identified by the beneficiary, family, and child and family team.
- C. MYPAC providers are required to provide or arrange for the provision of wraparound facilitation defined as the creation and facilitation of a child and family team for the purpose of developing a single individual service plan (ISP) to address the needs of the beneficiary with complex mental health challenges and their families. Wraparound facilitation must be provided in accordance with high fidelity and quality wraparound practice and include the following:
1. Engaging the family,
 2. Assembling the child and family team which includes:
 - a) The wraparound facilitator,
 - b) The beneficiary's service providers, any involved beneficiary serving agency representatives and other formal supports, as appropriate,
 - c) The caregiver/guardian,
 - d) Other family or community members serving as informal supports, as appropriate, and
 - e) Other identified youth, unless there are clear clinical indications this would be detrimental which are documented clearly throughout the medical record.
 3. Facilitating the child and family team meeting, at a minimum, once a month,
 4. Facilitating the development of an ISP through decisions made by the child and family team during the child and family team meeting, including a plan for anticipating, preventing and managing crisis,

5. Working with the child and family team in identifying providers of services and other community resources to meet the family and beneficiary's needs,
 6. Making necessary referrals for beneficiaries,
 7. Documenting and maintaining all information regarding the ISP, including revisions and child and family team meetings,
 8. Presenting ISP for approval to the child and family team,
 9. Providing copies of the ISP to the entire team including the beneficiary and family/guardian,
 10. Monitoring the implementation of the ISP and revising as necessary to achieve outcomes,
 11. Maintaining communication between all child and family team members,
 12. Evaluating the progress toward needs being met to ensure the referral behaviors have decreased,
 13. Leading the child and family team to discuss and ensure the supports and services continue to meet the caregiver and the beneficiary's needs,
 14. Educating new team members about the wraparound process,
 15. Maintaining team cohesiveness,
 16. Meeting face-to-face with a MYPAC beneficiary once a week,
 17. Meeting face-to-face with the family twice a month,
 18. Meeting with other collateral contacts related to ISP implementation at least three (3) times a week, and
 19. Ensuring MYPAC beneficiaries on medication(s) used in the treatment of the beneficiary's SED visit a doctor every ninety (90) days for medication management and monitoring, at a minimum.
- D. Intensive case management is provided to beneficiaries in MYPAC only under the 1915(c) Demonstration waiver and is defined by the Division of Medicaid as services that assist MYPAC participants and families in gaining access to needed mental health services, as well as medical, social, educational and other services, regardless of the funding source for the services in which access is gained and includes service coordination that involves finding and organizing multiple treatment and support options. Refer to the Rule 2.2.B.1.

- E. Respite care is provided to MYPAC beneficiaries only under the 1915(c) demonstration waiver and is defined by the Division of Medicaid as a planned break for families to give the parent/caregiver temporary relief from caregiving. Refer to the Rule 2.2.B.1. The two (2) types of respite care are:
1. In-home, or home and community-based respite care provided by responsible adults or trained counselors, and
 2. Out-of-home or institutional respite care provided by direct clinical staff in a PRTF or short-term treatment and crisis stabilization in an inpatient psychiatric hospital.
- F. MYPAC staff must be appropriately trained or professionally qualified to provide services for which they are responsible.
1. A psychiatrist:
 - a) Must participate in the development of the ISP and is a child and family team member.
 - b) Is responsible for medication management, which is defined by the Division of Medicaid as medication treatment and monitoring services which include the prescription of psychoactive medications by a physician/psychiatrist that are designed to alleviate symptoms and promote psychological growth and includes:
 - 1) Prescribing medication(s) to treat SED,
 - 2) Educating the child and family_team concerning the effects, benefits, and proper use and storage of any medication prescribed for the treatment of SED,
 - 3) Assisting with the administration or monitoring of the administration, of any medication prescribed for the treatment of SED, and
 - 4) Arranging for any physiological testing or other evaluation necessary to monitor the participant for adverse reactions to, or for other health-related issues that might arise in conjunction with, the taking of any medication prescribed for the treatment of SED.
 - c) Must be in a practice agreement with and supervise any licensed/certified Psychiatric Mental Health Nurse Practitioner (PMHNP) who assists with their responsibilities.
 - d) Must meet face-to-face or by telepsychiatry with the beneficiary and family at the frequency documented in the ISP.
 2. A master's level mental health therapist who:

- a) Provides psychotherapy defined by the Division of Medicaid as the intentional, face-to-face interaction between a mental health professional and a beneficiary which establishes a therapeutic relationship to resolve symptoms of the beneficiary's mental and/or emotional disturbance.
- b) MYPAC psychotherapy includes the following:
 - 1) Family Therapy is defined by the Division of Medicaid as psychotherapy between a mental health therapist and a beneficiary's family members or guardians, with or without the presence of the beneficiary, and
 - i) Promotes psychological and behavioral changes within families and meets on a regular basis.
 - ii) Can include Department of Human Services (DHS) representatives or foster family members, acting in loco parentis, for beneficiaries in the custody of the DHS,
 - 2) Group Therapy is defined by the Division of Medicaid as psychotherapy between a mental health therapist and at least two (2), but no more than eight (8), individuals at the same time, and promotes psychological and behavioral changes with groups typically meeting on a regular basis and includes, but not limited to, focusing on relaxation training, anger management and/or conflict resolution, social skills straining and self-esteem enhancement.
 - 3) Individual Therapy is defined as psychotherapy that takes place between a mental health therapist and a beneficiary reliant upon interaction between therapist/clinician and beneficiary to promote psychological and behavioral change.
- 3. Wraparound Facilitators who:
 - a) Are identified as only one (1) MYPAC provider staff for each beneficiary and family and ensures appropriate coordination of services are identified and accessed.
 - b) Facilitates the development of the ISP through decisions made by the wraparound team.
 - c) Facilitates the child and family team meetings and assures all team members have the opportunity to participate.
 - d) Assists the beneficiary and family team in identifying goals and interventions based on the strengths and needs of the child and family.
 - e) Ensures needed resources are in place for the family.

- f) Receives training to identify different levels of intervention on an Individualized Crisis Management Plan (ICMP), the different stages of crisis, and how a crisis may be defined differently by each family.
 - g) Accesses and links identified services to the beneficiary and family which must be completed before the beneficiary is discharged from MYPAC in order to achieve a successful transition.
 - h) Available twenty-four (24) hours a day, seven (7) days a week to a beneficiary and family for assistance.
 - i) Has completed the Introduction to Wraparound Three (3)-day training.
 - j) Must participate in ongoing coaching and training as defined by the Division of Medicaid or its designee.
4. A Wraparound Facilitator supervisor who:
- a) Has completed the Introduction to Wraparound three (3)-day training,
 - b) Must participate in ongoing coaching and training as required by the Division of Medicaid, and
 - c) Supervises staff providing services to beneficiaries and families a minimum of four (4) hours of clinical supervision per month provided through a combination of individual supervision, group supervision, peer consultation and participation in wraparound meetings. Documentation must clearly identify the supervision component.
5. A Provider Organization providing wraparound facilitation which:
- a) Must participate in the wraparound certification process through the Division of Medicaid or its designee, and
 - b) Must ensure the wraparound facilitator's case load does not exceed ten (10) cases.

Source: Miss. Code Ann. §§ 43-13-117(16), 43-13-117(46), 43-13-121, 43-14-1; 42 CFR §§ 441, Subpart D, 441.151(a)(2).

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

Rule 2.5: Individual Service Plans (ISP)

- A. For the purpose of this rule, an ISP may be referred to as the treatment plan, wraparound plan, or case management plan depending on the service which directs the treatment of the beneficiary.

- B. The Division of Medicaid defines the ISP as a written, detailed document that is integral to the wraparound process and is beneficiary/family driven. An ISP must be developed by the child and family team, and is individualized for each MYPAC beneficiary.
1. The ISP must include the following:
 - a) Services to be provided,
 - b) Frequency of service provision,
 - c) Staff providing each service and their qualifications,
 - d) Formal and informal supports available to the beneficiary and family, and
 - e) Plans for anticipating, preventing and managing crises.
 2. Each ISP must include an Individualized Crisis Management Plan (ICMP) which:
 - a) Is developed during the child and family team meeting based on the individualized preferences of the beneficiary and family.
 - b) Identifies triggers that may lead to potential crisis or risk and interventions and strategies to mitigate the risk that can be implemented to avoid the crisis.
 - c) Identifies natural supports that may decrease the potential for a crisis to occur.
 - d) Identifies specific needs of families and tailors the level of intervention.
 - e) Provides responses that are readily accessible at any time to the beneficiary and family.
 - f) Contains contact information for those involved at all levels of intervention during the crisis.
 - g) Provides for crisis debriefing after the crisis has been resolved.
 - h) Provides a copy of the ISP, ICMP and contacts to the beneficiary and family.
 3. The wraparound facilitator monitors the ISP continuously through face-to-face visits with the beneficiary and family.
 - a) The child and family team reviews the ISP at least every thirty (30) days through a child and family team meeting.
 - b) The ISP is updated or revised when warranted by changes in the beneficiary's needs.

- c) The full child and family team must participate in the development of the initial ISP, revisions of the ISP, and the discharge ISP.
- d) A licensed clinical staff member must attend each child and family team meeting and is responsible for submitting the ISP to the psychiatrist for review following the meeting at least every ninety (90) days.

Source: Miss. Code Ann. §§ 43-13-117(46), 43-13-121, 43-14-1; 42 CFR § 441, Subpart D.

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

Rule 2.6: Clinical Documentation Requirements

A. Beneficiary records must be complete, accurate, accessible and organized.

- 1. Clinical documents must include begin time and end time for each contact.
- 2. Records must be maintained for a period of five (5) years after the beneficiary reaches the age of twenty-one (21).
- 3. Refer to Maintenance of Records Part 200, Chapter 1, Rule 1.3.

B. Records must contain the following categories:

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

- 3) Complaints and grievances procedures, and
 - 4) Appeals and right to fair hearing.
2. Assessments must include:
- a) Psychiatric diagnostic evaluation or psychological diagnostic testing evaluation which must include documentation of the need for MYPAC level of care.
 - 1) If no evaluation has been conducted within the last twelve (12) months, one must be completed within sixty (60) days prior to admission,
 - 2) If an evaluation has been conducted within the last twelve (12) months, an update addendum must be completed within the fourteen (14) days following MYPAC admission.
 - b) Bio-psychosocial assessment that includes:
 - 1) Developmental profile,
 - 2) Behavioral assessment,
 - 3) Assessment of the potential resources of the beneficiary's family,
 - 4) Medical history,
 - 5) Current educational functioning, and
 - 6) Family and beneficiary strengths and needs
3. Treatment Planning must include:
- a) ISP signed and dated by the child and family team and in place within fourteen (14) days of enrollment in MYPAC, and reviewed with wraparound team every thirty (30) days,
 - b) ICMP included in the ISP,
 - c) Documentation treatment planning is occurring in the child and family team meetings, and
 - d) Treatment Planning is directed by the MYPAC beneficiary and family.
4. Services provided must include:

- a) Wraparound facilitation progress notes which document:
 - 1) The relationship of services to identified needs of family and beneficiary as stated in the ISP,
 - 2) Detailed narration from face-to-face meetings with the beneficiary and/or family, or collateral contacts, including setting, crisis, barriers and successes, and
 - 3) Date and signature of wraparound facilitator.

- b) Child and family team meeting notes which document:
 - 1) The purpose and results of services provided that are consistent with the needs outlined in the ISP,
 - 2) Changes to ISP, including dates and reason for changes,
 - 3) Treatment successes,
 - 4) Implementation of the ICMP and outcome, if used,
 - 5) Names and positions or roles of each team member, and
 - 6) Dates and signatures of participating team members.

- c) Medication management and monitoring documentation must include:
 - 1) Evidence the treating psychiatrist has managed all beneficiary SED medication(s) at least every ninety (90) days, including but not limited to, reviewing, revising, adjusting, discontinuing and monitoring.
 - 2) If the family chooses a different physician to prescribe medication(s) used in the treatment of the beneficiary's SED, the psychiatrist employed by the MYPAC provider as Medical Director must provide feedback on the implementation of the ISP.
 - 3) Medication(s) to treat the beneficiary's SED are accurately administered by the family in accordance with the physician or PMHNP's orders.
 - 4) Informed consent for medication(s) used in the management of the beneficiary's SED is signed by the parent/guardian and beneficiary, if age appropriate, identifying the symptoms the medications target and evidence education has been provided.
 - 5) Effectiveness of medication(s) to treat the beneficiary's SED.

- 6) Current medication(s) to treat the beneficiary's SED as reflected in the medication profile sheet.
 - 7) Assistance to family with obtaining, administering and monitoring any medication(s) prescribed for the treatment of the beneficiary's SED.
 - 8) Assessment for side effects of medication(s) to treat beneficiary's SED including physiological testing or other evaluations necessary to monitor for adverse reactions or other health related issues that might arise from taking medication(s) to treat beneficiary's SED.
 - 9) Regular monitoring of medication(s) to treat the beneficiary's SED by the MYPAC provider and reporting any inconsistencies to the treating psychiatrist.
- d) Psychotherapy notes must include:
- 1) Date of session,
 - 2) Time session began and time session ended,
 - 3) Specify if therapy is individual, family or group,
 - 4) Person(s) participating in session,
 - 5) Clinical observations about the beneficiary and/or family, including demeanor, mood, affect, mental alertness, and thought processes,
 - 6) Content of the session,
 - 7) Therapeutic interventions attempted and beneficiary/family's response to the intervention,
 - 8) Beneficiary's response to any significant others who may be present in the session,
 - 9) Outcome of the session,
 - 10) Statement summarizing the beneficiary and/or family's degree of progress toward the treatment goals,
 - 11) Signature, credentials and printed name of therapist, and
 - 12) Notes for each session. Monthly summaries are not acceptable in lieu of psychotherapy session notes.
5. Discharge planning documentation must include:

- a) Discharge planning began the first (1st) day of admission.
- b) Discharge planning is done with the beneficiary and family through the wraparound process.
- c) A signed copy of the final discharge plan with signatures of the MYPAC beneficiary and caregiver/guardian at the time of discharge.

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

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

Rule 2.7: Special Procedures

- A. The use of special procedures, including restraints or seclusion, for participants in a community setting is prohibited.
- B. If a participant enrolled in MYPAC is admitted to a PRTF for respite under the 1915(c) demonstration waiver, Medicaid rules and State and Federal regulations must be followed. Refer to Part 207, Chapter 4.

Source: Miss. Code Ann. § 43-13-121; 42 CFR §§ 441. Subpart D, 483, Subpart G.

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

Rule 2.8: Discharge/Transition Planning

- A. For all beneficiaries receiving MYPAC services, discharge planning must begin at the time of admission and the MYPAC provider is responsible for assisting the family with transition plans through the wraparound process.
- B. The wraparound facilitator must access and link appropriate services to the beneficiary and family prior to discharge from MYPAC services.
- C. Discharge from MYPAC services occurs when the beneficiary ;
 - 1. Reaches twenty-two (22) years of age or “ages out”,
 - 2. If applicable, or family utilizes their freedom of choice to end MYPAC services,
 - 3. Moves out of state,
 - 4. No longer meets the criteria or needs the intensity of services provided by MYPAC, or

5. Admits to an acute care facility or PRTF.
- D. At the time of the beneficiary's discharge from MYPAC services, the discharge/transition plan should be amended to include any of the following, if there is a change:
1. MYPAC services begin and end date,
 2. Reason for discharge,
 3. The name of the person or agency that cares for and has custody of the beneficiary,
 4. The physical location/address where the beneficiary resides,
 5. A list of the beneficiary's diagnoses,
 6. Detailed information about the beneficiary's prescribed medication(s) to treat the beneficiary's SED including the names, strengths and dosage instructions in layman's language and any special instructions, including but not limited to, lab work requirements,
 7. Information connecting the beneficiary and family with community resources and services, including but not limited to:
 - a) Address of where follow-up mental health services will be obtained with contact name and phone number.
 - b) Name and address of the school the beneficiary will attend with name and contact information of identified educational staff.
 - c) Other recommended resources, including recreational, rehabilitative, or other special programs including the corresponding contact information.
 - d) Date, time, and location of any scheduled appointments.
 8. Detailed and specific recommendations in writing about the beneficiary's participation in the MYPAC program including successful techniques in areas of behavior management, mental health treatment and education, and
 9. The offer of a full array of community-based mental health services for beneficiaries.
- E. At the time of the beneficiary's discharge from MYPAC, the provider must give the parent/guardian:
1. A written copy of the final discharge plan, and

2. A written prescription for a thirty (30) day supply of all medications used for the management of the beneficiary's SED if the current supply does not exceed thirty (30) days.

F. The provider must obtain signed consent from the beneficiary and family to provide copies of the final discharge plan to the providers of follow-up mental health, education and other agreed-upon services to be provided after discharge.

Source: Miss. Code Ann. §§ 43-13-117(46), 43-13-121, 43-14-1; 42 CFR 441, Subpart D.

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

Rule 2.9: Grievances, Appeals and Fair Hearings

A. The Division of Medicaid defines grievances as a complaint filed about unfair treatment.

1. MYPAC providers must:

- a) Maintain records of all grievances received,
- b) Track grievances and responses, and
- c) Establish a grievance system that includes written policies and procedures,

2. MYPAC providers must report to the Division of Medicaid:

- a) All grievances by beneficiaries and/or family members or third parties on behalf of beneficiaries within two (2) business days of receipt, and
- b) Submit a quarterly summarization of each grievance, either on-going or resolved, reported during the quarter.

B. The Division of Medicaid defines an appeal as a formal request to change an adverse decision by the MYPAC provider who must:

1. Have a written appeal process with policies and procedures which includes a Notice of Action defined as a notification to the beneficiary/family within ten (10) days before the date of termination, suspending or reducing any services by the MYPAC provider,
2. Forward any formal appeal requests including the Notice of Action to the Division of Medicaid within two (2) business days of receipt,
3. Submit a quarterly report to the Division of Medicaid summarizing each appeal, either on-going or resolved, that was received during the quarter, and

4. Participate, at the provider's sole expense, in any review, appeal, fair hearing or litigation involving issues related to MYPAC at the request of the Division of Medicaid.
- C. The Division of Medicaid defines a fair hearing as a process initiated when a beneficiary or family disagrees with an adverse decision following an appeal to the MYPAC provider.
1. The beneficiary or family must request an appeal and receive an adverse decision from the provider prior to requesting a fair hearing.
 2. Refer to Part 300 Appeals, Chapter 1: Appeals, Rule 1.3: Administrative Hearings for Beneficiaries.

Source: Miss. Code Ann. § 43-13-121; 42 CFR §§ 438 Subpart F, 431 Subpart E.

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

Rule 2.10: Critical Incidents Occurrences

- A. The Division of Medicaid defines critical incidents as any occurrence that results in injury, abuse, neglect or exploitation of a MYPAC beneficiary. MYPAC providers must have written policies for documenting and reporting all critical incidents/occurrences which must include the following:
1. Reporting of critical incidents in writing within one (1) business day to the Division of Medicaid.
 2. Reporting any suspected abuse or neglect to the Mississippi Department of Human Services (DHS) and participate in investigations.
 3. A written description of events and actions.
 4. Documentation that explains follow-up, resolution, and debriefing.
- B. Certain critical incidents that must be reported include, but are not limited to:
1. Life-threatening injuries,
 2. Allegations of staff misconduct,
 3. Allegations of sexual activity between MYPAC beneficiaries and providers,
 4. Allegations of abuse or neglect of a beneficiary, and/or
 5. Runaway of a participant.

Source: Miss. Code Ann. § 43-13-1.

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

Rule 2.11: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of this Title, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121.

History: Added eff. 12/01/2013.

Chapter 3: Pre-Admission Screening and Resident Review (PASRR) Level II

Rule 3.1: Pre-Admission Screening and Resident Review (PASRR) Level II

- A. The Pre-Admission Screening and Resident Review (PASRR) Level I must be performed prior to admission to a Medicaid certified nursing facility (NF) to: [Refer to Miss. Admin. Code Part 207 for PASRR Level I]
1. Assess the person's clinical eligibility and need for nursing facility (NF) services,
 2. Confirm whether or not the person has a mental illness (MI), an intellectual disability/developmental disability (ID/DD) and/or a related condition (RC), and/or
 3. Assess whether the person requires specialized rehabilitative services or supplemental services and supports.
- B. If the PASRR Level I confirms that a person has MI, ID/DD and/or a RC, or if specialized rehabilitative services or supplemental services and supports are required, then the person must complete a PASRR Level II.
- C. A PASRR Level II ensures the appropriate placement of persons with MI, ID/DD, and/or a RC and the provision of needed services to persons who have been diagnosed with MI, ID/DD, and/or a RC.
1. RCs are defined as conditions that are not an intellectual disability, but which produce similar functional impairment and require similar treatment or services.
 2. RCs:
 - a) Must emerge before the age of twenty-two (22),
 - b) Are expected to continue indefinitely, and
 - c) Must result in substantial functional limitations in three (3) or more of the following

major life activities:

- 1) Self-care,
 - 2) The understanding and use of language,
 - 3) Learning,
 - 4) Mobility,
 - 5) Self-direction,
 - 6) Capacity for independent living, and/or
 - 7) Economic sufficiency.
3. RCs include, but are not limited to,
- a) Autism,
 - b) Cerebral palsy,
 - c) Down syndrome,
 - d) Fetal alcohol syndrome,
 - e) Muscular dystrophy,
 - f) Multiple sclerosis,
 - g) Seizure disorder, and
 - h) Traumatic brain injury (TBI).

B. A PASRR Level II consists of two (2) types:

1. An initial PASRR Level II is defined as the first PASRR Level II completed on a person whose PASRR Level I indicated MI, ID/DD and/or a RC so that appropriateness of NF placement can be determined and the need for specialized services be identified and recommended.
2. A subsequent PASRR Level II is defined as any PASRR Level II completed after an initial PASRR Level II when there is a significant change in the physical, mental, or emotional condition of a NF resident.
 - a) The significant change is for persons with previously identified MI, ID/DD and/or RC

whose needs have changed as well as for persons with newly discovered or suspected MI, ID/DD and/or RC.

- b) The purpose of a subsequent PASRR Level II is to assess whether or not the resident is still appropriate for the NF level of care and/or if a change in the need or type of specialized services is required.

C. The Division of Medicaid defines:

1. Specialized rehabilitative services as a subcategory of NF services which are individualized services and supports which a NF provides for persons who need them and are included in the NF per diem.
2. Supplemental services and supports, referred to as specialized services, as any services and supports for persons with MI or ID/DD, other than specialized rehabilitative services, for a particular NF person and not included in the NF per diem.

Source: 42 C.F.R. § 483; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 06/01/19.

Rule 3.2: Appropriateness Review Committee (ARC)

A. The Appropriateness Review Committee (ARC), administered by the Mississippi Department of Mental Health (DMH), is responsible for:

1. Reviewing the PASRR Level II,
2. Determining the appropriateness of nursing facility (NF) placement for persons with mental illness (MI), an intellectual disability/developmental disability (ID/DD) and/or a related condition (RC), and
3. Assessing whether the person requires specialized rehabilitative services or supplemental services and supports.

B. The ARC members must have a current Mississippi license and practice within the scope of their license:

1. To review the PASRR Level II for MI:
 - a) A psychiatrist who serves as the designated State Mental Health Authority Representative, and
 - b) A registered nurse (RN).
2. To review the PASRR Level II for ID/DD:

- a) A psychiatrist who serves as the designated State Intellectual Disabilities Authority Representative, and
- b) A registered nurse (RN), and
- c) Healthcare professionals credentialed with a minimum of a Master's degree in a health related field, such as a licensed clinical social worker (LCSW) or licensed medical social worker (LMSW).

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

History: Revised eff. 06/01/19.

Rule 3.3: Advanced Group Determinations by Category

- A. Advanced group determinations by category permits the nursing facility (NF) to omit the PASRR Level II in certain circumstances that are time-limited or where the need for the NF is clear or the need for specialized services is unlikely provided that the person is not a danger to themselves or others, if their exempting conditions are documented, and the Appropriateness Review Committee (ARC), after reviewing this documentation, determines that a PASRR Level II is not required.
- B. Examples of categories include, but are not limited to:
 - 1. Terminal illness,
 - 2. Severe physical illnesses including, but not limited to:
 - a) Coma, or
 - b) Ventilator dependent,
 - 3. Provisional admission pending further assessment in cases of delirium where a diagnosis cannot be made until the delirium clears,
 - 4. Emergency protective services with a stay lasting no longer than seven (7) days, or
 - 5. Very brief and finite stays of up to a fixed number of days to provide respite to in-home caregivers to whom the person with MI or ID/DD is expected to return following the brief NF stay.
- C. If the evaluator believes that the person would benefit from specialized services despite the presence of conditions considered to be in an exempted category, the evaluator must refer the person for a PASRR Level II.

D. Findings for an advanced group determination must be documented in the PASRR Level I and must, at a minimum:

1. Identify the name and professional title of the person recommending the determination and the date of the recommendation,
2. Identify the specific condition(s) which qualifies the person for exemption from the PASRR Level II,
3. If applicable, describe the nature of any further assessment(s) needed to determine the most appropriate setting and/or specialized services for the person,
4. Identify, to the extent possible, based on the available information, NF services that may be needed, including any mental health, specialized services and/or specialized rehabilitative services, and
5. Include evidence to support the evaluator's conclusions.

Source: 42 C.F.R. § 483.130; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 06/01/19.

Rule 3.4: Pre-Admission Screening and Resident Review (PASRR) Level II Process

- A. The Division of Medicaid requires any person admitted to a Medicaid certified nursing facility (NF) have a completed Pre-Admission Screening and Resident Review (PASRR) Level II prior to admission to the NF if the PASRR Level I indicated that the person had a mental illness (MI), intellectual disability/developmental disability (ID/DD), and/or a related condition (RC) unless that person has an approved documented advanced group determination.
- B. The hospital transferring or nursing facility (NF) admitting the person must electronically complete and submit the PASRR Level I located in the Envision web portal prior to the NF admission. The completed PASRR must be faxed to the Division of Medicaid if the provider is not a Mississippi Medicaid Provider.
- C. The Division of Medicaid's PASRR Contractor is responsible for:
 1. Reviewing all PASRR Level I which indicate MI, ID/DD and/or a RC,
 2. For MI, determining if a face-to-face assessment or an on-the-record review is the most appropriate in completing the PASRR Level II and making a recommendation for NF placement and any specialized services required to the MI Appropriateness Review Committee (ARC) within five (5) business days,
 3. For ID/DD, notifying the Department of Mental Health's (DMH's) ARC within five (5) business days of receiving a referral of any PASRR Level I which indicates an ID/DD

and/or a RC.

4. Determining if a PASRR Level II is required for a change of condition.

D. DMH's ARC is responsible for:

1. Reviewing any PASRR Level I which indicates ID/DD and/or a RC,
2. Determining if a face-to-face assessment or an on-the-record review is the most appropriate in completing the PASRR Level II, and
3. Forwarding the final recommendations to the State PASRR Coordinator at the Mississippi State Hospital within two (2) business days of receipt.

E. The MI ARC is responsible for:

1. Reviewing the PASRR Level II recommendations from the Division of Medicaid's PASRR Contractor,
2. Making any changes to the recommendations received, and
3. Forwarding the final recommendations to the State PASRR Coordinator at the Mississippi State Hospital within two (2) business days of receipt.

F. The State PASRR Coordinator is responsible for submitting the recommendations to the designated State Intellectual Disabilities Authority Representative for the final decision on NF placement and required specialized services who must make the final determination within seven (7) to nine (9) business days from the date of the original PASRR Level I submittal triggering a PASRR Level II.

G. The NF must complete and submit a PASRR Level II State Request Form to the Division of Medicaid's PASRR Contractor when a significant change in the person's physical, mental, and/or emotional condition becomes apparent.

Source: 42 C.F.R. § 483; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 06/01/19.

Rule 3.5: Qualification Requirements for Pre-Admission Screening and Resident Review (PASRR) Level II Evaluators

The Pre-Admission Screening and Resident Review (PASRR) Level II for:

A. Mental illness (MI) must be completed by:

1. A qualified mental health professional, as designated by the Department of Mental Health (DMH),

2. A person duly licensed and/or certified as a Certified Mental Health Therapist (CMHT), Licensed Certified Mental Health Therapist (LCMHT), Licensed Certified Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Master Social Worker (LMSW), Licensed Professional Counselor (LPC), psychologist or registered nurse (RN) who must conduct the psychosocial assessment portion of the PASRR Level II, and
 3. A psychiatrist, psychologist or psychiatric mental health nurse practitioners (PMHNP) who must complete the psychiatric history and evaluation.
- B. ID/DD must be completed by an interdisciplinary team of Diagnostic and Evaluation (D&E) professionals who possess the following credentials, at a minimum:
1. A Certified Intellectual and Developmental Disability Therapist (CIDDT), Licensed Clinical Intellectual and Developmental Disability Therapist LCIDDT), LSW, psychologist, RN or other DMH approved personnel who must complete the social history and adaptive behavior assessment.
 2. A psychologist who approves and signs the psychological assessment completed by DMH approved personnel and
 3. A physician, nurse practitioner, or an RN who must complete the medical summary.

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

History: Revised eff. 06/01/19.

Rule 3.6: Specialized Rehabilitative Services and Specialized Services

- A. Specialized rehabilitative services are defined as rehabilitative services which a nursing facility (NF) is required to provide to meet the daily physical, social, functional or mental health needs of its persons and include, but are not limited to:
1. Physical therapy,
 2. Speech/language therapy,
 3. Occupational therapy, and
 4. Mental Health Rehabilitative Services for mental illness (MI) and/or intellectual disability/development disability (ID/DD).
- B. The NF must provide the specialized rehabilitative services necessary for the well-being of its persons even if the specialized rehabilitative services are not specifically mentioned in the Medicaid State Plan and cannot charge the person a fee for the specialized rehabilitative services because they are covered NF services.

- C. A NF is not obligated to provide specialized rehabilitative services if no current person requires the services but if a resident develops the need for a specialized rehabilitative service after admission, the NF must either provide the specialized rehabilitative service or obtain the service from an outside resource.

- D. Mental health rehabilitative services for MI, ID/DD and/or a related condition (RC) are specialized rehabilitative services which the NF is required to provide to meet the daily mental health needs of its persons. These services include, but are not limited to:
 - 1. Consistent implementation, during the person's daily routine and across settings, of systematic plans which are designed to change inappropriate behaviors,
 - 2. Administering and monitoring the effectiveness and side effects of medications which are prescribed to change inappropriate behavior or to alter manifestations of psychiatric illness,
 - 3. Provision of a structured environment for those persons who are determined to need structure such as structured socialization activities to diminish tendencies toward isolation and withdrawal,
 - 4. Development, maintenance, and consistent implementation across settings of those programs designed to teach persons the daily living skills they need to be more independent and self-determining. Program focus may include but not be limited to grooming, personal hygiene, mobility, nutrition, health, medication management, mental health education, money management, and maintenance of the living environment,
 - 5. Development of appropriate personal support networks, or
 - 6. Formal behavior modification programs.

- E. If mental health rehabilitative services for MI, ID/DD and/or RC services are needed by a person, they must be provided by the NF regardless of whether the need was identified through the PASRR process, and regardless of whether the person requires other specialized services through another Medicaid provider.

- F. Specialized Services for persons with MI are the services specified by the ARC that include treatment other than routine nursing care, supportive therapies, and supportive counseling by NF staff. This includes services that, combined with services provided by the NF, result in the continuous and aggressive implementation of an individualized plan of care that will aid the person in attaining the highest practicable level of physical, mental and psychosocial well-being, and:
 - 1. Is developed and monitored by an interdisciplinary team, which includes a physician, qualified mental health professionals and, as appropriate, other professionals;
 - 2. Prescribes specific therapies and activities for the treatment of person experiencing an

acute episode of serious MI, which necessitates supervision by trained mental health personnel; and

3. Is directed toward the diagnosis and reduction of the person's behavioral symptoms that necessitate institutionalization and that aid the person to improve his/her level of independent functioning, and achieve a functioning level that permits reduction in the intensity of mental health services to below the level of specialized services at the earliest possible time.

G. Specialized services for persons with MI provided by Community Mental Health Centers (CMHCs) or Private Mental Health Centers (PMHCs) include, but are not limited to:

1. Medication Evaluation and Monitoring defined as an intentional face-to-face interaction between a physician or a nurse practitioner and a person for the purpose of assessing the need for psychotropic medication, prescribing medications and regular periodic monitoring of the medications prescribed for therapeutic effect and medical safety,
2. Individual Therapy defined as one-on-one psychotherapy that takes place between a mental health therapist and a person,
3. Family Therapy defined as psychotherapy that takes place between a mental health therapist and a person's family members, with or without the presence of the person. Family therapy may also include others with whom the resident has a family-like relationship. However, meetings with NF staff that do not include the person is not considered family therapy,
4. Group Therapy defined as psychotherapy that takes place between a mental health therapist and at least two (2), but no more that twelve (12) residents at the same time. Possibilities include, but are not limited to, groups that focus on coping with or overcoming depression, adaptation to changing life circumstances and self-esteem enhancement, and
5. Psychosocial Rehabilitation defined as a program of structured activities, designed to support and enhance the ability of NF persons to function at the highest possible level of independence. The structured activities target the specific needs and concerns of the NF persons and aim to improve reality orientation, social adaptation, physical coordination, daily living skills, time and resource management, task completion and other areas of competence that promote independence in daily life. Structured activities are designed to aid in alleviating such psychiatric symptoms as confusion, anxiety, disorientation, distraction, preoccupation, isolation, withdrawal and feelings of low self-worth.

H. Specialized services for persons with MI, ID/DD and/or RCs include, but are not limited to, specialized services that constitute a continuous active treatment program, that includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services directed toward:

1. The acquisition of the behaviors necessary for the person to function with as much self-

determination and independence as possible.

2. The prevention or deceleration of regression or loss of current optimal functional status. Specialized services are not services provided to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.
 3. Short-term provision of any one (1) or a combination of the following services for the person during the temporary acute and/or sub-acute need:
 - a) Inpatient psychiatric services,
 - b) Medication evaluation and monitoring by a psychiatrist or similarly credentialed professional, such as a Psychiatric Nurse Practitioner, to evaluate patient response to psychotropic medications and to modify medication orders,
 - c) Individual, family, and/or group therapy services, and
 - d) Psychosocial rehabilitation services, and
 - e) Senior psychosocial rehabilitation.
- I. Specialized services provided by community service providers certified by DMH include, but are not limited to:
1. Training targeted toward amelioration of identified basic skill deficits and/or maladaptive behavior,
 2. Priority training needed to achieve greater levels of independence and self-determination, and
 3. Aggressive implementation of a systematic program of formal and informal techniques and competent interactions continuously targeted toward achieving a measurable level of skill competency specified in written objective, based on a comprehensive interdisciplinary evaluation, and conducted in all client settings and by all personnel involved with the person.
- J. The Division of Medicaid considers specialized services as any disability related supports and services provided to a NF person with a PASRR condition that aids the person to attain the highest practicable level of physical, mental, and psychosocial well-being that includes, but is not limited to:
1. A short-term intensive intervention for a maximum of six (6) months promoting the successful adaptation to the NF and/or to improve the resident's quality of life during the NF stay.

2. A short-term intensive intervention, that promotes a successful NF discharge and community reintegration, for persons with a capacity for community reintegration, within the ensuing three (3) to six (6) month period. These services are provided to promote the mission of Olmstead and other similar reintegration and diversion initiatives promoting successful community reintegration through targeted, time-limited, and goal directed services for persons with ID/DD who have the capacity for such transition.
3. Services include short-term services for a maximum of six (6) months depending on the identified needs of the person with the provision of one (1) or a combination of the following services that include, but are not limited to:
 - a) Independent living skills development,
 - b) Community living/integration skills development,
 - c) Re-socialization skills development, and
 - d) Behavior support and intervention services.

Source: 42 C.F.R. §§ 483.45, 483.440; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revise eff. 06/01/19.

Rule 3.7: Confidentiality Safeguards

- A. The Division of Medicaid's Pre-Admission Screening and Resident Review (PASRR) Level II Contractor is responsible for notifying the person and the person's legal and/or designated representative in writing that the person is suspected of having a mental illness (MI), an intellectual disability/developmental disability (ID/DD) and/or a related condition (RC), and that a PASRR Level II is required.
- B. The Division of Medicaid's PASRR Level II Contractor must involve the person being evaluated and include the person's legal and/or designated representative, along with the person's family, if possible.
 1. The person and the person's legal and/or designated representative must agree to family participation.
 2. If the legal and/or designated representative is not able to attend the PASRR Level II, he or she may give consent for the PASRR Level II to proceed without his or her presence.
- C. The Division of Medicaid's PASRR Level II Contractor must ensure all notices are adapted to the cultural background, language, ethnic origin and means of communication used by the person being evaluated and must interpret and explain the results of the PASRR Level II to the person and legal and/or designated representative.

- D. Interdisciplinary coordination must occur and be documented when more than one (1) evaluator performs any portion of the PASRR Level II Evaluation.
- E. The gathering of information necessary for determining whether it is appropriate for the person with MI, ID/DD and/or a RC to be placed in a NF or in another appropriate setting must occur throughout all applicable portions of the PASRR Level II process.
 - 1. All information must be considered and recommendations must be based upon a comprehensive analysis of all data concerning the person.
 - 2. Evaluators are allowed to use available data, obtained prior to initiation of the PASRR process, as long as the available data is considered valid, accurate, and appears to reflect the current functional status of the person.
 - 3. To supplement and verify that the existing data is current and accurate, it may be necessary for the Division of Medicaid's PASRR Level II Contractor or the Department of Mental Health's (DMH's) Regional Center IDD Program to gather additional information to assess proper placement and treatment.
 - 4. Information is only allowed to be obtained and/or released with properly executed consents.
- F. In accordance with State Law, all Appropriateness Review Committee (ARC) PASRR Level II determinations must be maintained by the PASRR State Coordinator's Office.
 - 1. All PASRR Level II determinations, and any relevant information, must be placed and remain in the person's active medical chart at the NF they are admitted to and maintained in accordance with State Law.
 - 2. The recommendations in the PASRR Level II Summary of Findings Report must be addressed in the NF plan of care.
 - 3. The PASRR Level II determinations, and any relevant information, must be sent to any new NF if the person transfers to another NF.

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

History: Revised eff. 06/01/19.

Rule 3.8: Reconsideration and Appeal

- A. If a person or his/her legal or designated representative does not agree with the Appropriateness Review Committee (ARC) Determination, he/she has a right to appeal the decision.
- B. The person must first request a reconsideration of the ARC Determination within ten (10)

days of the date of the ARC determination notice and must be made directly to the Division of Medicaid's PASRR Level II Contractor for a mental illness (MI) determination or the Department of Mental Health's (DMH's) Regional Center Intellectual/Development Disability (IDD) Program for an ID/DD or a related condition (RC) determination.

- C. If a person or his/her legal or designated representative does not agree with the outcome of the reconsideration, he/she has a right to request a fair hearing from the Division of Medicaid. [Refer to Miss. Admin. Code Part 300]

Source: 42 C.F.R. 431 Subpart E; 42 C.F.R. §§ 431.10, 483.108, 483.204; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 06/01/19.

Rule 3.9: Reimbursement for PASRR Level II Evaluations

- A. The Division of Medicaid reimburses the Pre-Admission Screening and Resident Review (PASRR) Level II Contractor for services rendered when the Contractor:

- 1. Completes and sends a PASRR Level II Billing Summary for MI monthly to the State PASRR Coordinator for review, and
- 2. Submits an invoice via Paymode to be electronically processed for reimbursement.

- B. The Division of Medicaid reimburses the Department of Mental Health (DMH) Regional Center Intellectual/Developmental Disability (IDD) Program when DMH:

- 1. Submits the PASRR Level II Roster for ID to the State PASRR Coordinator for review, and
- 2. Depending upon the person's Medicaid eligibility status, reimbursement will be processed accordingly by the Division of Medicaid.

- C. The Division of Medicaid only reimburses for PASRR Level IIs which are:

- 1. Complete, and
- 2. Signed by the appropriate personnel who completed the assessments that are part of the PASRR Level II.

- D. The Division of Medicaid does not reimburse for:

- 1. Incomplete PASRR Level IIs,
- 2. Therapeutic services provided by community mental health centers (CMHCs) or private community health centers (PMHCs) in a nursing facility (NF) to persons who do not have

an Appropriateness Review Committee (ARC) determination recommending the service,

3. PASRR Level II for persons who have a primary diagnosis of Alzheimer's disease or other dementia which prevents them from benefitting from specialized services or those deemed to be in an advanced determination category, or
4. Multiple services provided for a person conducted and/or billed simultaneously.

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

History: Revised eff. 06/01/19.