



MISSISSIPPI DIVISION OF
MEDICAID

Administrative Code

Title 23: Medicaid
Part 206
Mental Health Services

Table of Contents

Title 23: Medicaid.....	1
Table of Contents	1
Title 23: Division of Medicaid.....	1
Part 206: Mental Health Services.....	1
Part 206 Chapter 1: Community Mental Health Services	1
Rule 1.1: Provider Requirements	1
Rule 1.2: Definitions	4
Rule 1.3: Covered Services	8
Rule 1.4: Non-Covered Services.....	17
Rule 1.5: Reimbursement.....	18
Rule 1.6: Documentation.....	18
Chapter 2: Refer to Part 223	19
Chapter 3: Pre-Admission Screening and Resident Review (PASRR) Level II	19
Rule 3.1: Pre-Admission Screening and Resident Review (PASRR) Level II.....	19
Rule 3.2: Appropriateness Review Committee (ARC).....	21
Rule 3.3: Advanced Group Determinations by Category	22
Rule 3.4: Pre-Admission Screening and Resident Review (PASRR) Level II Process.	23
Rule 3.5: Qualification Requirements for Pre-Admission Screening and Resident Review (PASRR) Level II Evaluators	24
Rule 3.6: Specialized Rehabilitative Services and Specialized Services.....	25
Rule 3.7: Confidentiality Safeguards	29
Rule 3.8: Reconsideration and Appeal.....	30
Rule 3.9: Reimbursement for PASRR Level II Evaluations.....	31

Title 23: Division of Medicaid

Part 206: Mental Health Services

Part 206 Chapter 1: Community Mental Health Services

Rule 1.1: Provider Requirements

- A. All providers of community mental health services must:
1. Provide proof of certification by the Mississippi Department of Mental Health (MDMH), professional license, or certification and/or license from the appropriate agency as required by the Division of Medicaid,
 2. Provide proof that the services they provide have been certified by the appropriate agency when applicable,
 3. Meet the applicable requirements described in Miss. Admin Code Part 200, Chapter 4,
 4. Provide a National Provider Identifier (NPI), verification from the National Plan and Provider Enumeration System (NPPES), and
 5. Submit written confirmation from the Internal Revenue Service (IRS) of the Provider's tax identification number and legal business name.
- B. Rehabilitative services must be provided by the following licensed and enrolled providers acting within their scope of practice:
1. Board-certified or board-eligible psychiatrists licensed by the Mississippi Board of Medical Licensure.
 2. Physicians licensed by the Mississippi Board of Medical Licensure acting within their scope of practice.
 3. Physician Assistants (PA) must hold a Master's degree in a health related or science field, be licensed by the Mississippi Board of Medical Licensure, and must be under the supervision of a psychiatrist or a physician.
 4. Psychiatric Mental Health Nurse Practitioners (PMHNP) must hold a Master's degree in nursing with a specialty in psychiatry, be licensed by the Mississippi Board of Nursing, and must practice within a collaborative/consultative relationship with a physician within an established protocol or practice guidelines.
 5. Psychologists must hold a Ph.D. degree in psychology and be licensed by the Mississippi Board of Psychology.

6. Licensed Certified Social Workers (LCSW) must hold a Master's degree in social work and be licensed by the Mississippi State Board of Examiners for Social Workers and Marriage and Family Therapists at the LCSW level.
7. Licensed Professional Counselors (LPC) must hold a Master's degree in counseling and be licensed by the Mississippi State Board of Examiners for Licensed Professional Counselors. Provisionally Licensed Professional Counselors (P-LPCs) may provide services within the scope of their provisional license.
8. Quasi-governmental Community Mental Health Center (CMHC) agencies and private mental health centers (PMHCs) certified according to Mississippi Code Ann. § 41-4-7 by the Mississippi Department of Mental Health (DMH).
 - a. DMH issues a four (4) year certification for CMHCs/PMHCs and the services provided unless stated otherwise at the time of certification.
 - b. DMH certification is based on the following:
 - 1) Adherence to DMH standards, DMH grant requirement guidelines, contracts, memoranda of understanding, and memoranda of agreement;
 - 2) Compliance with DMH fiscal management standards and practices outlined in the DMH Operational Standards based on a risk-based audit system;
 - 3) Evidence of fiscal compliance with external funding sources;
 - 4) Compliance with ethical practices and codes of conduct of professional licensing entities related to provision of services and management of the organization; and
 - 5) Evidence of solid business and management practices.
 - c. Staff qualifications for CMHC/PMHC:
 - 1) Qualifications for providers listed in Miss. Admin. Code Part 206, Rule 1.1.B.1. through B.8 above are applicable in CMHC/PMHC,
 - 2) Professional Art Therapists (ATR-BC) must hold a Master's degree in art therapy and be licensed by the Mississippi Department of Health.
 - 3) Registered Nurses (RN) must be a graduate from an approved or accredited RN nursing program, be licensed by the Mississippi Board of Nursing, and must be under the supervision of a psychiatrist, physician, PMHNP, or PA.
 - 4) Licensed Practical Nurses (LPN) must be a graduate from an approved or accredited LPN nursing program, be licensed by the Mississippi Board of Nursing and supervised by a psychiatrist, physician, PMHNP, PA or RN.

- 5) Licensed Marriage and Family Therapists (LMFT) must hold a Master's degree in marriage and family therapy and be licensed by the Mississippi State Board of Examiners for Social Workers and Marriage and Family Therapists.
- 6) DMH certifies the following staff:
 - (a) Certified Mental Health Therapists (CMHT), Certified Intellectual and Developmental Disabilities Therapists (CIDDT) and Certified Addiction Therapists (CAT) must hold a Master's degree in mental health, human services, intellectual disabilities, addictions, or behavioral health related fields from an approved educational institution.
 - (1) Provisionally certified therapists are temporarily certified while fulfilling all the certification requirements, provide the same services as a CMHT, CIDDT and CAT and must be under the supervision of certified therapist of the same discipline. Provisional certification is valid for up to twenty-four (24) consecutive months from the date of issuance.
 - (2) The certified credential is full certification and renewable every four (4) years as long as renewal requirements are met.
 - (b) Community Support Specialists must hold a minimum of a Bachelor's degree in a mental health field, be certified by DMH as a Community Support Specialist and must be under the supervision of staff listed Miss. Admin. Code Part 206, Rule in 1.1.B.1. and B.8.
 - (c) Peer Support Specialist Professionals must hold a minimum of a high school diploma or GED equivalent, , be certified by DMH as a Certified Peer Support Specialist and must be under the supervision of a psychiatrist, physician, PMHNP, PA, LCSW, LPC, LMFT, CMHT, CIDDT, CAT or a Peer Support Specialist Supervisor who has been trained as a Peer Support Specialist with an emphasis on supervision.
 - (d) Peer Support Specialist supervisors must hold a minimum of a master's degree in addictions, mental health, intellectual/developmental disabilities, or human or behavioral services field and either a 1) professional license or 2) a DMH credential as a Mental Health Therapist, Intellectual/Developmental Disability Therapist, or Addictions therapist prior to or immediately upon acceptance of a Peer Support Specialist Supervisory position and must also receive training specifically developed for Peer Support Specialist supervisors by DMH.
 - (e) Certified Wraparound Facilitators must hold a minimum of a bachelor's degree in a mental health, intellectual/developmental disabilities, or human services/behavioral health-related field and a DMH Community Support

Specialist credential and complete the “Introduction to Wraparound” 3-day training, be certified by DMH, and must be under the supervision of a psychiatrist, physician, PMHNP, PA, LCSW, LPC, LMFT, CMHT, CIDDT, or a CAT who has completed the “Introduction to Wraparound” 3-day training and hold a DMH High Fidelity Wraparound certificate.

- 7) Staff members 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 of the same discipline.

C. Evidence-based practices (EBP) or evidence-informed best practices 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: 42 C.F.R. §§ 440.130, 440.169; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised and renumbered to correspond with MS SPA 20-0022 (eff. 09/01/20) eff. 11/01/2020.

Rule 1.2: Definitions

The Division of Medicaid defines:

- A. Assessment as obtaining from the beneficiary, beneficiary’s family or others involved in the beneficiary’s care, 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 beneficiary’s or family’s problem(s), the factors contributing to the problem(s), and the most appropriate course of treatment for the beneficiary.
- B. Acute Partial Hospitalization as 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 hospital to outpatient hospital or community 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.
- C. A Brief Emotional/Behavioral Health Assessment as a brief screening used to assess a beneficiary’s emotional and/or behavioral health and covers a variety of standardized assessments aimed to identify the need for more in-depth evaluation for a number of mental/behavioral conditions.

- D. Clinical Staff member as a staff member who holds, at a minimum, a master's degree and professional license or who is a DMH Certified Mental Health Therapist (CMHT), DMH Certified Intellectual and Developmental Disabilities Therapist (CIDDT) or a DMH Certified Addiction Therapist (CAT) when appropriate.
- E. Community Support Services as services that are specific, measurable, and individualized that focus on the beneficiary'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 and include the following as clinically indicated:
1. Identification of strengths which aid the beneficiary in their recovery and the barriers that will challenge the development of skills necessary for independent functioning in the community.
 2. Individual therapeutic interventions that directly increase the 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 which includes:
 - a) Identification and self-management of the prescribed medication regimen and communication with the prescribing provider.
 - b) Training of family, unpaid caregivers, and/or others who have a legitimate role in addressing the needs of the beneficiary.
 5. Direct interventions in de-escalating 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. Facilitation of the Individual Service Plan or Recovery Support Plan which includes the active involvement of the beneficiary and the people identified as important in the beneficiary's life.
- F. Crisis Residential Services as medically monitored residential short-term psychiatric stabilization services provided in a setting other than an acute care hospital or a long-term residential treatment facility which consist of no more than sixteen (16) beds.
- G. Crisis Response Services as time-limited intensive intervention provided by trained crisis response staff, available twenty-four (24) hours a day, seven (7) days a week and includes the

assessment of the crisis and ability to activate a mobile crisis team, crisis stabilization and treatment of a beneficiary to avoid inpatient hospitalization.

- H. Family Therapy as face-to-face psychotherapy between a mental health therapist and a beneficiary's family members, with or without the presence of the beneficiary, which may also include others with whom the beneficiary lives or has a family-like relationship. Family Therapy includes family psychotherapy, psychoeducation, and family-to-family training.
- I. Group Therapy as face-to-face psychotherapy addressing the needs of several individuals within a group.
- J. Individual Therapy as face-to-face, one-on-one psychotherapy that takes place between a mental health therapist and a beneficiary.
- K. Intensive Community Outreach and Recovery Team (ICORT) Services as a team-oriented approach to mental health rehabilitation intervention and supports necessary to assist beneficiaries in achieving and maintaining rehabilitative, resiliency and recovery goals with a severe and persistent mental illness.
- L. Interactive Complexity in:
 - Group therapy as psychotherapy using non-verbal communication and/or physical aids between a mental health therapist and no more than six (6) individuals under the age of twenty-one (21) at the same time.
 - 2. Individual therapy as the one-on-one psychotherapy using non-verbal communication and/or physical aids between a mental health practitioner and a beneficiary who have not yet developed or have lost their expressive communication ability or do not have the cognitive ability to understand the mental health practitioner if ordinary language is used.
- M. Medication Administration as the administering of a prescribed medication.
- N. Medication Evaluation as regular and periodic monitoring of the therapeutic and side effects of psychotropic medications prescribed for the treatment of a mental illness.
- O. Multifamily Group Therapy as therapy taking place between a licensed and enrolled provider or CMHC/PMHC staff and family members of at least two (2) different beneficiaries in a group setting.
- P. Nursing assessment as an assessment of a beneficiary's psychological, physiological and sociological history.
- Q. Peer Support Services as 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.

- R. Program of Assertive Community Treatment (PACT) as therapeutic programs provided in the community in which beneficiaries live that would traditionally need inpatient care and treatment but can be maintained in a less restrictive/community-based setting.
- S. Psychiatric Diagnostic Evaluation as an integrated biopsychosocial assessment, including history, mental status, and recommendations.
- T. Psychological Evaluation as the assessment of a beneficiary's cognitive, emotional, behavioral, and social functioning by a licensed psychologist using standardized tests, interviews, and behavioral observations.
- U. Psychosocial Rehabilitation as an active treatment program designed to support and restore community functioning and well-being of an adult beneficiary who has been diagnosed with a serious and persistent mental illness by providing systematic, curriculum based interventions for skills development and to promote recovery in the beneficiary's community by alleviating psychiatric decompensation, confusion, anxiety, feelings of low self-worth, isolation and withdrawal.
- V. Psychotherapeutic Services as intentional, face-to-face interactions, conversations or non-verbal encounters 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.
- W. Quasi-governmental CMHCs are defined as entities operated under the supervision of regional commissions appointed by county boards of supervisors comprising their respective catchment areas.
- X. Senior Psychosocial Rehabilitation as a program of structured activities designed to support and enhance the ability of senior beneficiaries to function at the highest possible level of independence in the most integrated community setting appropriate to their needs.
- Y. Targeted Case Management as services furnished to assist chronically mentally ill beneficiaries who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services
- Z. Treatment Plan as the plan that directs the treatment of the beneficiary and may be referred to as the plan of care, individualized service plan, wraparound plan or person-centered plan depending on the services provided.
- AA. Treatment Plan Development and Review as the development and review of an overall treatment plan that directs the treatment and support of the person receiving services by qualified mental health providers.

Source: 42 C.F.R. §§ 440.130, 440.169; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised and renumbered to correspond with MS SPA 20-0022 (eff. 09/01/20) eff. 11/01/2020.

Rule 1.3: Covered Services

- A. The Division of Medicaid covers four (4) medically necessary mental health assessments by a non-physician per fiscal year when:
 - 1. Completed during the intake process and/or when there is a need for reassessment.
 - 2. Provided by a staff member who holds a master's degree and professional license or is one (1) of the following as appropriate:
 - a) A Department of Mental Health (DMH) Certified Mental Health Therapist (CMHT),
 - b) DMH Certified Intellectual and Developmental Disabilities Therapist (CIDDT), or
 - c) A DMH Certified Addiction Therapist (CAT).
- B. The Division of Medicaid covers up to twelve (12) brief emotional/behavioral health assessments when administered via a standardized behavioral or emotional assessment tool when medically necessary to identify emotional and/or behavioral conditions, including, but not limited to:
 - 1. Depression,
 - 2. Alcohol, substance use or substance abuse,
 - 3. Attention Deficit Hyperactivity Disorder (ADHD), or
 - 4. Other behavioral disorders that may require treatment and/or other forms of intervention.
- C. The Division of Medicaid covers four (4) medically necessary treatment plan development and reviews per state fiscal year when:
 - 1. Part of a treatment plan approved by one (1) of the providers listed in Miss. Admin. Code Title 23, Part 206, Rule 1.1.B.1 through B.8., and
 - 2. Provided by one of the providers listed in Miss. Admin. Code Title 23, Part 206, Rule 1.1 B.1 through B.8 or B.9.c.
- D. The Division of Medicaid covers medically necessary Targeted Case Management which must include:
 - 1. Completion of a comprehensive assessment and periodic reassessments of beneficiary needs to determine the need for services, including:

- a) Beneficiary history,
 - b) Identifying the needs of the beneficiary and completing related documentation, and
 - c) Gathering information from other sources to form a complete assessment/reassessment of the beneficiary.
2. Development and periodic revisions of a specific treatment plan that is based on the information collected through the assessment/reassessments that:
- a) Specifies the goals and actions to address the medical, social, educational, and other services needed by the beneficiary,
 - b) Includes activities such as ensuring the active participation of the eligible beneficiary, and working with the beneficiary or the beneficiary's authorized health care decision maker and others to develop those goals,
 - c) Identifies a course of action to respond to the assessed needs of the eligible beneficiary,
 - d) Provides referral and related activities, such as scheduling appointments for the beneficiary, to address any identified needs including medical, social, educational providers, or other programs and services to address identified needs and achieve goals specified in the treatment plan.
3. Monitoring and follow-up activities including:
- a) Activities and contacts necessary to ensure the treatment plan is implemented and adequately addresses the beneficiary's needs, which may include with the family members, service providers, or other entities or individuals conducted as frequently as necessary including at least one (1) annual monitoring, to determine whether the following conditions are met:
 - b) Services are being furnished in accordance with the beneficiary's treatment plan;
 - c) Services in the treatment plan are adequate; and
 - d) Changes in the needs or status of the beneficiaries are reflected in the treatment plan. Monitoring and follow-up activities at least annually include making necessary adjustments in the treatment plan and service arrangements with providers.
- E. The Division of Medicaid covers medically necessary crisis response services that meet the DMH standards of operation.
1. Crisis response services include:

- a) Assessment,
 - b) De-escalation, and
 - c) Service coordination and facilitation.
2. Crisis response teams must include:
- a) A Certified Peer Support Professional with specific roles and responsibilities,
 - b) A licensed and/or Credentialed Master's Level Therapist with experience and training in crisis response,
 - c) A Community Support Specialist with experience and training in crisis response,
 - d) A Crisis Response Coordinator for the provider's catchment area who is a licensed and/or credentialed master's level therapist with a minimum of two (2) years' experience and training in crisis response, and
 - e) At least one (1) employee with experience and training in crisis response to each population served by the provider.
- F. The Division of Medicaid covers up to sixty (60) days of medically necessary crisis residential services per state fiscal year when ordered by a psychiatrist, physician, psychologist, psychiatric mental health nurse practitioner (PMHNP) or physician assistant (PA) and prior authorized by the Division of Medicaid, Utilization Management/Quality Improvement Organization (UM/QIO) or designee.
1. Crisis residential services must provide the following within twenty-four (24) hours of admission:
- a) Initial assessment,
 - b) Medical screening,
 - c) Drug toxicology screening, and
 - d) Psychiatric consultation.
2. Crisis residential services include:
- a) Treatment plan development and review,
 - b) Medication management,

- c) Nursing assessment,
 - d) Individual therapy,
 - e) Family therapy,
 - f) Group therapy, and
 - g) Skill building groups such as social skills training, self-esteem building, anger control, conflict resolution and daily living skills.
3. Crisis residential room and board is not covered by the Division of Medicaid.
 4. Crisis residential providers must maintain staffing ratios according to DMH standards.
- G. The Division of Medicaid covers up to four hundred (400) fifteen (15) minute units per state fiscal year of medically necessary community support services.
1. Community support services must include:
 - a) Resource coordination that directly increases the acquisition of skills needed to accomplish the goals set forth in the treatment plan.
 - b) Monitoring and evaluating the effectiveness of interventions, as documented by symptom reduction and progress toward goals.
 - c) Psychoeducation:
 - On the identification and self-management of prescribed medication regimen and communication with the prescribing provider.
 - And training of family, unpaid caregivers, and/or others who have a legitimate role in addressing the needs of the beneficiary.
 - d) Direct interventions in de-escalating situations to prevent crisis.
 - e) Home and community visits for the purpose of monitoring the beneficiary's condition and orientation.
 - f) Assisting the beneficiary and natural supports in implementation of therapeutic interventions outlined in the treatment plan.
 2. Community support services must be provided by a Certified Community Support Specialist professional.

- H. The Division of Medicaid covers up to four (4) units of medically necessary psychiatric diagnostic evaluations per state fiscal year when prior authorized by the Division of Medicaid, UM/QIO or designee.
- I. The Division of Medicaid covers up to four (4) hours of medically necessary psychological diagnostic evaluations per state fiscal year when prior authorized by the Division of Medicaid, UM/QIO or designee and entirely completed by a psychologist.
- J. The Division of Medicaid covers medically necessary medication evaluation and management services.
 - 1. Medication evaluation and management services provided by community/private mental health centers are not limited.
 - 2. Medication evaluation and management services provided by independent practitioners within their scope of practice are subject to the physician visit limits in Miss. Admin. Code Title 23, Part 203, Rule 9.5.C.1.
 - 3. Medication evaluation and management must be provided by one (1) of the following:
 - a) Psychiatrist,
 - b) Physician,
 - c) PMHNP, or
 - d) PA.
- K. The Division of Medicaid covers medically necessary medication administration per state fiscal year when provide by one (1) of the following:
 - 1. Psychiatrist,
 - 2. Physician,
 - 3. PMHNP,
 - 4. PA,
 - 5. RN, or
 - 6. LPN.
- L. The Division of Medicaid covers up to one hundred forty-four (144), fifteen (15) minute units of nursing assessments performed by an RN per state fiscal year.

- M. The Division of Medicaid covers the following medically necessary psychotherapeutic services when part of a treatment plan approved by one (1) of the providers listed in Miss. Admin. Code Part 206, Rule 1.1.B.1 through B.8. and provided by one of the providers listed in Miss. Admin. Code Part 206, Rule 1.1.B.1 through B.8. or B.9.c) as appropriate:
1. Up to thirty-six (36) individual therapy sessions per state fiscal year,
 2. Up to twenty-four (24) family therapy sessions per state fiscal year,
 3. A combined total of up to forty (40) group therapy or multi-family group therapy sessions per state fiscal year, and
 4. Interactive complexity for individual and group therapy as appropriate within yearly limits.
- N. The Division of Medicaid covers up to one hundred (100) days of medically necessary acute partial hospitalization services when prior authorized by the Division of Medicaid, UM/QIO or designee.
1. Acute partial hospitalization includes, but is not limited to:
 - a) Treatment plan development and review,
 - b) Medication management,
 - c) Nursing assessment,
 - d) Individual therapy,
 - e) Group therapy, and
 - f) Family therapy.
 2. Acute partial hospitalization programs must be provided by licensed/certified providers including, but not limited to:
 - a) CMHC/PMHC,
 - b) The outpatient department of a hospital or free-standing psychiatric unit, or
 - c) A private psychiatric clinic.
- O. The Division of Medicaid covers up to five (5) hours per day, five (5) days per week of medically necessary psychosocial rehabilitation when prior authorized by the Division of Medicaid, UM/QIO or designee.

1. Psychosocial rehabilitation services are not covered when provided on the same day as group therapy, senior psychosocial rehabilitation, crisis residential services or acute partial hospitalization.
 2. Psychosocial rehabilitation services must be included in a treatment plan approved by one (1) of the providers listed in Miss. Admin. Code Title 23, Rule 1.1.B.1 through B.8.
 3. Senior psychosocial rehabilitation service must be provided according to DMH standards for that population.
- P. The Division of Medicaid covers one thousand six hundred (1600) fifteen minute units per state fiscal year of medically necessary assertive community treatment services provided through Programs of Assertive Community Treatment (PACT).
1. PACT is an all-inclusive service that includes, but is not limited to:
 - a) Treatment plan review and development,
 - b) Medication management,
 - c) Individual therapy,
 - d) Family therapy,
 - e) Group therapy,
 - f) Community support, and
 - g) Peer support.
 2. The composition of the PACT team members must include, but is not limited to:
 - a) A team leader,
 - b) A Psychiatrist or PMHNP,
 - c) RN,
 - d) Master's level mental health professional,
 - e) Substance use disorder specialist,
 - f) Employment specialist,
 - g) Certified peer support specialist professional, and

- h) Other clinical personnel as determined by DMH.
- Q. The Division of Medicaid covers up to two hundred and seventy (270) days per year of medically necessary intensive community outreach and recovery team (ICORT) services when prior authorized by the Division of Medicaid, UM/QIO or designee.
- 1. ICORT services include:
 - a) Treatment plan development and review,
 - b) Medication management,
 - c) Individual therapy and family therapy in the home,
 - d) Group therapy,
 - e) Peer support services,
 - f) Community support services,
 - g) Skill building groups, including but not limited to:
 - 1) Social skills training,
 - 2) Self-esteem building,
 - 3) Anger control,
 - 4) Conflict resolution, and
 - 5) Daily living skills.
 - 2. ICORT providers must have the following staff:
 - a) Team Leader which must be a full-time Master's Level Mental Health Therapist,
 - b) A full-time registered nurse,
 - c) A full-time equivalent Certified Peer Support Specialist Professional,
 - d) A part-time clerical personnel, and
 - e) If deemed necessary by the DMH, a part-time Community Support Specialist must be added to ICORT.

3. ICORT services must be included in a treatment plan approved by one (1) of the providers listed in Miss. Admin. Code. Title 23, Part 106, Rule 1.1.B.1. through B.8.
 4. Development and revision of a specific treatment plan based on the information collected through the assessment which must include:
 - a) Goals and actions to address the medical, social, educational, and other services needed by the beneficiary,
 - b) Activities such as ensuring the active participation of the beneficiary and working with the beneficiary or beneficiary's representative and others to develop goals, and
 - c) A course of action to respond to the assessed needs of the beneficiary.
 5. Referral and related activities to help the beneficiary obtain needed services, including but not limited to:
 - a) Scheduling appointments, and
 - b) Linking the beneficiary with medical, social and educational providers or other programs and services that provide needed services as identified in the treatment plan.
 6. Monitoring and follow-up activities to ensure the treatment plan is effectively implemented and adequately addresses the needs of the beneficiary conducted annually and as necessary to ensure:
 - a) Services are being furnished in accordance with the beneficiary's treatment plan,
 - b) Services in the treatment plan are adequate, and
 - c) Any necessary changes to the treatment plan are made based on any changes in the needs or status of the beneficiary.
- R. The Division of Medicaid covers up to two hundred (200) fifteen (15) minute units per state fiscal year of medically necessary peer support services.
1. Peer support services must include:
 - a) Development of a recovery support plan, and
 - b) Skill building for coping with and managing symptoms while utilizing natural resources, and the preservation and enhancement of community living skills.
 2. Services must be provided by a certified Peer Support Specialist Professional.

Source: 42 C.F.R. §§ 440.130, 440.169; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised and renumbered to correspond with MS SPA 20-0022 (eff. 09/01/20) eff. 11/01/2020.

Rule 1.4: Non-Covered Services

A. The Division of Medicaid does not cover community mental health services that:

1. Have not been certified by the Department of Mental Health (DMH),
2. Do not meet the standards specified by DMH,
3. Are not medically necessary,
4. Are not prior authorized by the Division of Medicaid, Utilization Management/Quality Improvement Organization (UM/QIO) or designee, if required, and
5. Are not part of a plan of care or treatment plan approved by a team member qualified to approve the service being provided.

B. The Division of Medicaid does not cover the following activities and/or services:

1. Time spent completing paperwork,
2. Telephone contacts, unless included in the service definition,
3. Recreational activities,
4. Educational interventions,
5. Travel time,
6. Missed or canceled appointments,
7. Room and board, and/or
8. Services provided to a beneficiary during an inpatient stay, unless included in the service definition.

C. The Division of Medicaid does not cover services and/or programs that do not meet the standards of the licensing/certifying agency when applicable.

Source: 42 C.F.R. §§ 440.130, 440.169; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised and renumbered to correspond with MS SPA 20-0022 (eff. 09/01/20) eff. 11/01/2020.

Rule 1.5: Reimbursement

- A. The Division of Medicaid reimburses for covered community mental health services according to a statewide uniform fee schedule.
- B. Reimbursement for physician services provided outside of a Community or Private Mental health center are subject to the limits described in Miss. Admin. Code Title 23, Part 203.
- C. Intensive Community Outreach and Recovery Team (ICORT) providers must provide at least thirty (30) minutes of service in one (1) day in order for the Division of Medicaid to reimburse the per diem rate.

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

History: Revised and renumbered to correspond with MS SPA 20-0022 (eff. 09/01/20) eff. 11/01/2020.

Rule 1.6: Documentation

- A. All services must be documented on a treatment plan and approved, signed and dated by a licensed practitioner operating within their scope of practice.
- B. The following must be documented in the beneficiary's case record for each service provided:
 - 1. Type of service provided,
 - 2. Date of service,
 - 3. Length of time spent providing the service,
 - 4. Start and end times of sessions,
 - 5. Names of all individuals receiving or participating in the service,
 - 6. Summary of session,
 - 7. Explanation of how the service relates to the goals and objectives established in the treatment plan,
 - 8. Name and title of servicing provider, and
 - 9. Signature and credentials of servicing provider/practitioner.

- C. Community mental health services must be documented according to the Department of Mental Health (DMH) Record Guide and any supplemental instructions provided by DMH in effect at the time the service is provided.

Source: 42 C.F.R. §§ 440.130, 440.169; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised and renumbered to correspond with MS SPA 20-0022 (eff. 09/01/20) eff. 11/01/2020

Chapter 2: Refer to Part 223

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.