



MISSISSIPPI DIVISION OF  
**MEDICAID**

## Administrative Code

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Title 23: Medicaid  
Part 223  
Early and Periodic Screening,  
Diagnosis, and Treatment (EPSDT)

## Table of Contents

Title 23: Medicaid.....	1
Table of Contents.....	1
Chapter 1: General .....	2
Rule 1.1: Program Description .....	2
Rule 1.2: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Provider Enrollment.....	3
Rule 1.3: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Provider Participation Requirements.....	3
Rule 1.4: Periodicity Schedule.....	5
Rule 1.5: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Screenings .	5
Rule 1.6: Documentation Requirements for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Screenings.....	8
Rule 1.7: Diagnostic and Treatment Program Services .....	11
Rule 1.8: Reimbursement.....	11
Chapter 2: Early Intervention / Targeted Case Management.....	12
Rule 2.1: Provider Participation.....	12
Rule 2.2: TCM Activities.....	13
Rule 2.3: Quality Assurance and Monitoring .....	14
Rule 2.4: Freedom of Choice.....	15
Rule 2.5: Reimbursement.....	15
Chapter 3: Prescribed Pediatric Extended Care (PPEC) Services.....	16
Rule 3.1: Definitions.....	16
Rule 3.2: Provider Requirements.....	16
Rule 3.3: Covered Services.....	17
Rule 3.4: Non-covered Services .....	18

Rule 3.5: Reimbursement.....	18
Rule 3.6: Documentation .....	19
Chapter 4: Private Duty Nursing .....	20
Rule 4.1: Definitions.....	20
Rule 4.2: Provider Requirements.....	21
Rule 4.3: Covered Services.....	26
Rule 4.4: Prior Authorization and Concurrent Reviews .....	28
Rule 4.5: Discontinuation of Private Duty Nursing (PDN) Services.....	29
Rule 4.6: Non-Covered Services.....	30
Rule 4.7: Denial of Services and Appeals .....	31
Rule 4.8: Reimbursement.....	31
Rule 4.9: Documentation Requirements .....	31
Chapter 5: Personal Care Services.....	33
Rule 5.1: Definitions.....	33
Rule 5.2: Provider Requirements.....	33
Rule 5.3: Covered Services.....	37
Rule 5.4: Prior Authorization and Concurrent Reviews .....	39
Rule 5.5: Discontinuation of Personal Care Services (PCS) .....	41
Rule 5.6: Non-Covered Services.....	41
Rule 5.7: Denial of Services and Appeals .....	42
Rule 5.8: Reimbursement.....	43
Rule 5.9: Documentation Requirements .....	43
Chapter 6: Expanded Rehabilitative Services .....	44
Rule 6.1: Definitions.....	44
Rule 6.2: Provider Requirements .....	45
Rule 6.3: Covered Services.....	47
Rule 6.4: Non-Covered Services.....	53

Rule 6.5: Reimbursement.....	54
Rule 6.6: Documentation .....	55

## **Title 23: Division of Medicaid**

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

#### **Chapter 1: General**

##### *Rule 1.1: Program Description*

- A. The Division of Medicaid has established a program of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) which provides screenings, preventive and comprehensive health services for certain beneficiaries who are eligible for full Medicaid benefits. EPSDT services are provided to beneficiaries under age twenty-one (21).
- B. EPSDT stands for:
1. Early is assessing health care in early life so that potential disease and disabilities can be prevented or detected in their preliminary states, when they are most effectively treated.
  2. Periodic is assessing a child's health at regular, recommended intervals in the child's life to assure continued healthy development.
  3. Screening is the use of tests and procedures to determine if children being examined have conditions warranting closer medical or dental attention.
  4. Diagnosis is the determination of the nature or cause of conditions identified by the screening.
  5. Treatment is the provision of services needed to control, correct or lessen health problems.
- C. Providers of EPSDT screenings must be currently enrolled Mississippi Medicaid providers, have signed an EPSDT specific provider agreement, and must adhere to the American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule. EPSDT screening providers include, but are not limited to:
1. The Mississippi State Department of Health,
  2. Public schools and/or public school districts certified by the Mississippi Department of Education,
  3. Federally Qualified Health Centers (FQHC),
  4. Rural Health Clinics (RHC),
  5. Comprehensive health clinics, and

6. Similar agencies which provide various components of EPSDT screenings.

D. EPSDT diagnostic and treatment services are primarily provided by referral to other enrolled Mississippi Medicaid providers.

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

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

*Rule 1.2: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Provider Enrollment*

A. Physicians, physician assistants or nurse practitioners who wish to provide EPSDT screenings must meet the Mississippi Medicaid enrollment requirements, complete and sign an EPSDT specific provider agreement and pass an onsite clinic inspection performed by the Division of Medicaid.

B. Registered nurses employed through the Mississippi Department of Education (MDE), who meet the certification requirement and the established protocols mandated by the Mississippi State Department of Health (MSDH), MDE, Mississippi School Nurse Association, and Mississippi Board of Nursing, may perform EPSDT health assessments following the protocols established by the MSDH. MDE employed registered nurses must have the educational basis and clinical basis needed to perform health assessments. In addition to the certification requirement, claims submitted for these services must be submitted under the school's provider number and the billing provider must have a current letter of referral affiliation on file with the Division of Medicaid.

Source: 42 U.S.C § 1396d; Miss. Code Ann. § 43-13-121.

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

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

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

B. Dental providers must provide services to all EPSDT-eligible beneficiaries in accordance with the dental schedule of the American Academy of Pediatric Dentistry (AAPD) and in

accordance with AAP guidelines. Dental providers must provide or refer EPSDT-eligible beneficiaries with an identified need for additional assessment, diagnosis, and/or treatment services to an appropriate provider.

- C. EPSDT screening providers must refer EPSDT-eligible beneficiaries to other enrolled Mississippi Medicaid licensed practitioners of the beneficiary's choice for assessment, diagnosis and/or treatment services necessary to correct or ameliorate any physical, mental, psychosocial and/or behavioral health conditions discovered by the screenings, whether or not such services are covered under the State Plan.
- D. Off-site Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening providers must submit the following information to the Division of Medicaid:
  - 1. A completed and signed secondary location form documenting the off-site provider's ability to complete all age appropriate components of EPSDT screenings;
  - 2. An attestation that the EPSDT screenings will be completed by an approved EPSDT screening provider who has completed the Division of Medicaid's EPSDT provider agreement and that all required equipment and supplies are available at the off-site location.
  - 3. A signed agreement between the off-site location authority including, but not limited to, a school superintendent, principal, day care director, and the screening provider.
  - 4. A list of all physical addresses of the off-site locations where the EPSDT screenings will be provided and a monthly schedule for each location designating the dates and times the EPSDT screenings will be offered.
  - 5. Information packet materials including, but not limited to, letters, consent forms, and examples of anticipatory guidance information sheets to be provided which must be prior approved by the Division of Medicaid.
  - 6. A copy of the provider's Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or CLIA number, if applicable.
- E. EPSDT screenings cannot begin at an off-site location until an approval has been authorized in writing by the Division of Medicaid.

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

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

*Rule 1.4: Periodicity Schedule*

- A. EPSDT providers must adhere to the current American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule.
- B. EPSDT providers must schedule all health assessment screening appointments for the EPSDT-eligible beneficiary according to the AAP Bright Futures Periodicity Schedule.
- C. EPSDT providers must maintain a screening periodicity tracking system for EPSDT-eligible beneficiaries seen for initial screening to ensure that subsequent screenings are performed timely and in accordance to the AAP Bright Futures Periodicity Schedule. EPSDT-eligible beneficiaries, guardians and/or legal representatives must be informed of the AAP Bright Futures Periodicity Schedule.
  - 1. EPSDT providers must follow up on missed appointments. If the beneficiary fails to keep the scheduled appointment, or the beneficiary, guardian and/or legal representative fails to contact the provider to reschedule, an appointment letter or telephone contact must be made providing the beneficiary another opportunity to be screened within thirty (30) days of the initial appointment.
  - 2. Two (2) good faith efforts, defined as an attempt to contact the beneficiary, guardian and/or legal representative, are required to reschedule a screening appointment. EPSDT providers must document in the medical record any missed appointments and two (2) good faith efforts to reschedule the appointment.
  - 3. Failure of a beneficiary, guardian and/or legal representative to keep the second appointment and respond to the provider's attempted contact is considered a declination of that screening only. The provider must continue to maintain periodicity and schedule the beneficiary for the next screening due following the same process.

Source: 42 C.F.R § 441.58; Miss. Code Ann. §§ 43-13-117, 43-13-121.

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

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

- A. An initial or established age appropriate medical screening which must include at a minimum:
  - 1. A comprehensive health and developmental history including assessment of both physical and mental health development and family history,
  - 2. A comprehensive unclothed physical examination,
  - 3. Appropriate immunizations according to the Advisory Committee on Immunization Practices (ACIP), and specific to age and health history,



4. Laboratory tests adhering to the AAP Bright Futures Periodicity Schedule,
  5. Sexual development and sexuality screening adhering to the AAP Bright Futures Periodicity Schedule, and
  6. Health education, including anticipatory guidance.
- B. Developmental screening or surveillance to include diagnosis with referral to an enrolled Mississippi Medicaid provider for diagnosis and treatment for defects discovered.
- C. Psychosocial/behavioral assessment to include diagnosis with referral to an enrolled Mississippi Medicaid provider for diagnosis and treatment for defects discovered.
- D. Vision screening, at a minimum, to include diagnosis with referral to an enrolled Mississippi Medicaid optometry or ophthalmology provider for diagnosis and treatment for defects discovered.
- E. Hearing screening, at a minimum, to include diagnosis with referral to an enrolled Mississippi Medicaid audiologist, otologist, otolaryngologist or other physician hearing specialists for diagnosis and treatment for defects discovered.
- F. Dental screening, at a minimum, to include diagnosis with referral to an enrolled Mississippi Medicaid dental provider for beneficiaries at eruption of the first tooth or twelve (12) months of age for diagnosis and referral to a dentist for treatment and relief of pain and infections, restoration of teeth and maintenance of dental health.
- G. Maternal depression screening, to include a referral:
1. To an enrolled Medicaid provider if the mother is eligible for Medicaid, or
  2. To other healthcare providers as medically indicated including, but not limited to:
    - a) Federally Qualified Health Center (FQHC),
    - b) Rural Health Clinic (RHC), or
    - c) Community Mental Health Center (CMHC).
- H. The Division of Medicaid covers off-site screening at the following locations:
1. School,
  2. Daycare center, or
  3. Head start center.

- I. Off-site Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screening providers must:
  1. Provide off-site screenings only within the county or within forty (40) miles of the county where the physician's office, RHC or FQHC is located,
  2. Develop and adhere to confidentiality policies that are approved by the Division of Medicaid.
  3. Ensure medical personnel performing the physical examination are limited to Mississippi Medicaid enrolled physicians, nurse practitioners or a physician assistants employed by the physician's office, FQHC or RHC.
  4. Complete all age appropriate components of the EPSDT screening during one (1) visit or encounter.
  5. Have a designated well-lit private room to perform the screening assessments which must be in close proximity to:
    - a) Hot and cold running water, and
    - b) A bathroom.
  6. Obtain written parental/guardian consent:
    - a) The written consent must contain the following statements:
      - 1) Parent/guardian right to be present during EPSDT screenings,
      - 2) The physical examination will be unclothed,
      - 3) The EPSDT screenings take the place of the yearly wellness exam performed at the beneficiary's primary care provider's office, and
      - 4) Vaccines will be administered, if applicable,
    - b) Must include a space for the parent/guardian signature and date giving approval for the EPSDT screenings to be performed, and
    - c) Must be received within sixty (60) days prior to the EPSDT screenings.
  7. Encourage the parent/guardian to be present during the EPSDT screenings,
  8. Follow-up with the parent/guardian on the results of the screening by mail or in a one-on-one meeting.

9. Utilize the anticipatory guidance materials that are:

- a) Age appropriate,
- b) Mailed to the parent/guardian for beneficiaries under the age of fourteen (14).
- c) Given to beneficiaries fourteen (14) years of age and above.

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

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

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

*Rule 1.6: Documentation Requirements for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Screenings*

A. The medical record must include, at a minimum, documentation of the specific age appropriate screening requirements according to the American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule including the date the test or procedure was performed, the specific tests or procedures performed, the results of the tests or procedures or an explanation of the clinical decision to not perform a test or procedure in accordance with the AAP Bright Futures Periodicity Schedule, and documentation of the following:

- 1. Consent for screening with the beneficiary's and/or legal guardian/representative's signature,
- 2. Beneficiary and family history with appropriate updates at each screening visit, including, but not limited to, the following:
  - a) Psychosocial/behavioral history,
  - b) Developmental history, and
  - c) Immunization history,
- 3. Measurements, including, but not limited to:
  - a) Length/height and weight,
  - b) Head circumference,

- c) Weight for length percentiles,
  - d) Body mass index (BMI), and
  - e) Blood pressure,
4. Sensory screenings, subjective and/or objective:
- a) Vision, and
  - b) Hearing,
5. Developmental/behavioral assessment, as appropriate, including:
- a) Developmental screening to include, but not limited to:
    - 1) A note indicating the date the test was performed,
    - 2) The standardized tool used which must have:
      - (a) Motor, language, cognitive, and social-emotional developmental domains,
      - (b) Established reliability scores of approximately 0.70 or above,
      - (c) Established validity scores of approximately 0.70 or above for the tool conducted on a significant amount of children and using an appropriate standardized developmental or social-emotional assessment instrument, and
      - (d) Established sensitivity/specificity scores of approximately 0.70 or above, and
    - 3) Evidence of a screening result or screening score,
  - b) Autism screening,
  - c) Developmental surveillance,
  - d) Psychosocial/behavioral assessment,
  - e) Tobacco, alcohol and drug use assessment,
  - f) Depression screening, and
  - g) Maternal depression screening.
6. Unclothed physical examination,

7. Procedures, as appropriate, including, but not limited to:
  - a) Newborn blood screening,
  - b) Vaccine administration, if indicated,
  - c) Anemia testing,
  - d) Lead screening and testing,
  - e) Tuberculin test, if indicated,
  - f) Dyslipidemia screening,
  - g) Sexually transmitted infection screening,
  - h) Human immunodeficiency virus (HIV) testing,
  - i) Cervical dysplasia screening, and
  - j) Other pertinent lab and/or medical tests, as indicated,
8. Oral health, including:
  - a) Dental assessment,
  - b) Dental counseling, and
  - c) Referral to a dental home at the eruption of the first tooth or twelve (12) months of age,
9. Anticipatory guidance, including, but not limited to:
  - a) Safety,
  - b) Risk reduction,
  - c) Nutritional assessment, and
  - d) Supplemental Nutrition Assistant Program (SNAP) and Women, Infants and Children (WIC) status,
10. Appropriate referral(s) to other enrolled Mississippi Medicaid providers for diagnosis and treatment,
11. Follow-up on referral(s) made to other enrolled Mississippi Medicaid providers for

diagnosis and treatment,

12. Next scheduled EPSDT screening appointments, and

13. Missed appointments and any contacts or attempted contacts for rescheduling of EPSDT screening appointments.

B. Medical records must be available to the Division of Medicaid and/or designated entity upon request. [Refer to Maintenance of Records Miss. Admin. Code Part 200, Rule 1.3]

Source: Miss. Code Ann. §§ 43-13-117, 43-13-118, 43-13-121, 43-13-129.

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

*Rule 1.7: Diagnostic and Treatment Program Services*

The Division of Medicaid covers any medically necessary Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) diagnostic and treatment services required to correct or ameliorate physical, mental, psychosocial, and/or behavioral health conditions discovered by a screening, whether or not such services are covered under any Medicaid Administrative Rule or the State Plan for EPSDT-eligible beneficiaries and, if required, prior authorized by a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity. [Refer to Miss. Admin. Code Part 200, Rule 5.1].

Source: 42 U.S.C § 1396d; Miss. Code Ann. § 43-13-121.

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

*Rule 1.8: Reimbursement*

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

1. Developmental screenings according to the American Academy of Pediatrics (AAP) guidelines,
2. Vision screenings,
3. Hearing screenings,
4. Autism screenings,
5. Depression screenings,

6. Maternal depression screening, and
7. Other medically necessary services prior authorized by the Division of Medicaid or designee, if required:
  - a) Lab tests, excluding hemoglobin or hematocrit,
  - b) Diagnostic tests, and
  - c) Other procedures.

B. The Division of Medicaid reimburses EPSDT screening fees using Current Procedural Terminology (CPT) Codes based on the American Medical Association (AMA) methodology for determining medical services at ninety (90) percent of the Medicare fee schedule per state law.

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

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

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

## **Chapter 2: Early Intervention / Targeted Case Management**

### *Rule 2.1: Provider Participation*

#### A. Providers

1. Qualified providers shall be state agencies, private and public providers and their subcontractors.
2. Providers must meet the following Medicaid criteria to ensure that case managers for the children with developmental disabilities are capable of providing needed services to the targeted group:
  - a) Demonstrated successfully a minimum of three (3) years of experience in all core elements of case management including:
    - 1) Assessment,
    - 2) Care/services plan development,

- 3) Linking/coordination of services, and
- 4) Reassessment/follow-up.
- b) Demonstrated case management experience in coordinating and linking such community resources as required by the target population,
- c) Demonstrated experience with the target population, and
- d) Demonstrated the ability to provide or has a financial management system that documents services delivered and costs associated.

**B. Case Managers**

- 1. Each case manager must be a Mississippi Early Intervention Program certified service provider and have both of the following:
  - a) A bachelor's degree in child development, early childhood education, special education, social work, or be a registered nurse, and
  - b) Two (2) years' experience in service coordination for children with disabilities up to age eighteen (18) or two (2) years' experience in service provision to children under six (6) years of age.

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

*Rule 2.2: TCM Activities*

A. Early Intervention/Targeted Case Management (EI/TCM) is an active ongoing process that involves activities carried out by a case manager to assist and enable a child enrolled and participating in the Mississippi Early Intervention Program to gain access to needed medical, social, educational and other services. Service Coordination to assist the child and child's family, as it relates to the child's needs, from the notice of referral through the initial development of the child's needs identified on the Individualized Family Services Plan (IFSP). Additionally, Service Coordination assists the child and child's family, as it relates to the child's needs, with ongoing service coordination, for the child, provided by the individual service coordinator selected at the time the IFSP is finalized.

**B. These activities include:**

- 1. Arranging for evaluation and assessment activities to determine the identification of services as it relates to the child's medical, social, educational and other needs,
- 2. Arranging for and coordinating the development of the child's IFSP,



3. Arranging for the delivery of the needed services as identified in the IFSP,
4. Assisting the child and his/her family, as it relates to the child's needs, in accessing needed services for the child and coordinating services with other programs,
5. Monitoring the child's progress by making referrals, tracking the child's appointments, performing follow-up on services rendered, and performing periodic reassessments of the child's changing service needs,
6. Make a minimum of one (1) face-to-face contact quarterly and documented successful contacts monthly,
7. Obtaining, preparing and maintaining case records, reports, documenting contacts, services needed, and the child's progress,
8. Providing case consultation, with the service providers/collaterals in determining child's status and progress,
9. Coordinating crisis assistance, intervention on behalf of the child, making arrangements for emergency referrals and coordinating other needed emergency services, and
10. Coordinating the transition of an enrolled child to ongoing services prior to the child's third (3rd) birthday.

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

*Rule 2.3: Quality Assurance and Monitoring*

- A. The Division will establish and maintain an assurance process that ensures a quality case management program and the delivery of necessary covered services that appropriately address the individual needs. The provider agrees to share data as part of the quality assurance program timely upon request by the Division.
- B. The providers will make available to the Division the documentation/records maintained for case management services with the following information:
  1. The name of eligible client,
  2. Dates of case management services,
  3. The nature, content, and units of the case management services received and whether goals specified in the care plan have been achieved,
  4. Whether the client has declined services in the care plan, the need for and occurrences of coordination with other case managers,

5. The time line for obtaining needed services,
6. The time line for reevaluation of the plan,
7. Case Management Needs Assessment to determine the services needed and requested by the individual,
8. Service Coordination and Linkage to identify, assess, and link eligible individuals with the appropriate medical, social, and educational services to ensure that appropriate services are being provided while reducing duplication of services, and
9. Individual Service Monitoring to assure that all services are being appropriately delivered according to the Individualized Family Service Plan (IFSP) and in accordance with the established time lines.

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

*Rule 2.4: Freedom of Choice*

- A. Enrolled and participating recipients will have free choice of the available providers of case management services; and
- B. Enrolled and participating recipients will have free choice of the available providers of other medical care under the plan.

Source: Miss. Code Ann. § 43-13-121; Section 1920(a) (23) of the Social Security Act.

*Rule 2.5: Reimbursement*

- A. The Division of Medicaid uses rate setting as a prospective method of reimbursement on both the state and federal level. This method does not allow for retrospective settlements. The rates are determined from cost reports and appropriate audits.
- B. Standard rates will be re-determined annually. The Division of Medicaid uses a fee-for-service reimbursement rate for private providers. In no case may the reimbursement rate for services provided exceed an individual facility's customary charge to the public for such services in the aggregate, except for those public facilities rendering such services free of charge or at a nominal charge.
- C. Payments under the plan do not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.
- D. Case management providers are paid on a unit of service basis that does not exceed fifteen (15) minutes.

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

### **Chapter 3: Prescribed Pediatric Extended Care (PPEC) Services**

#### *Rule 3.1: Definitions*

The Division of Medicaid defines:

- A. Early and Periodic Screening, Diagnosis and Treatment (EPSDT)-eligible beneficiaries as beneficiaries who qualify for the federally mandated EPSDT program according to 42 U.S.C. § 1396d and 42 C.F.R. Part 441.
- B. Prescribed pediatric extended care (PPEC) services as medically necessary skilled nursing services and therapeutic interventions for EPSDT eligible, medically complex beneficiaries who:
  - 1. Are medically or technologically dependent, and
  - 2. Require continual care.
- C. PPEC center as any building or buildings, or other place, whether operated for profit or non-profit, which undertakes through its ownership or management to provide basic nonresidential services to three (3) or more medically dependent or technologically dependent children who are not related to the owner or operator by blood, marriage or adoption and who require such services.
- D. Medically or technologically dependent as requiring on-going, physician prescribed, technologically-based skilled nursing supervision and/or requiring routine use of a medical device to compensate for the deficit of life-sustaining body function due to a medical condition/disability whether acute, chronic or intermittent in nature.
- E. Medically complex as a medical condition that requires continual care as prescribed by the child's attending physician.

Source: 42 U.S.C. § 1396d; Miss. Code Ann. §§ 41-125-3, 43-13-117, 43-13-121.

History: Revised to correspond with SPA 19-0002 (eff. 01/01/2020), eff. 02/01/2020.

#### *Rule 3.2: Provider Requirements*

- A. Prescribed pediatric extended care (PPEC) providers, including out-of-state providers, must satisfy all requirements set forth in Miss. Admin Code Title 23, Part 200, Rule 4.8 in addition to the following provider type specific requirements:
  - 1. National Provider Identifier (NPI) verification from National Plan and Provider Enumeration System (NPPES).

2. Written confirmation from the Internal Revenue Service (IRS) confirming the provider's tax identification number and legal business name.
  3. A copy of the provider's current Medicare certification or Tie-In Notice from the Medicare Administrative Contractor. An Explanation of Medicare Benefits (EOMB) is not acceptable.
  4. A copy of License from the Mississippi State Department of Health, Health Facilities Licensure and Certification. If parent entity is an out-of-state facility with a servicing location in Mississippi, a copy of the respective State's license is required.
- B. PPEC providers must adhere to the Mississippi State Department of Health Minimum Standards of Operation of PPEC Centers, as required for Licensure.
- C. PPEC providers must development, implement and monitor the comprehensive plan of care, developed in conjunction with the parent or guardian, which specifies the medical, nursing, psychosocial and developmental therapies required.

Source: 42 U.S.C § 1396d; Miss. Code Ann. §§ 41-125-19, 43-13-117, 43-13-121.

History: Revised to correspond with SPA 19-0002 (eff. 01/01/2020), eff. 02/01/2020.

*Rule 3.3: Covered Services*

- A. The Division of Medicaid covers up to twelve (12) hours per day of medically necessary prescribed pediatric extended care (PPEC) services for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) eligible beneficiaries when:
1. Ordered by the beneficiary's attending physician,
  2. Provided by a Mississippi licensed and Medicaid enrolled PPEC center, and
  3. Prior authorized by the Division of Medicaid or designee:
    - a) Prior authorizations must be submitted every six (6) months, and
    - b) The ordering physician must perform an in-person evaluation of the beneficiary a minimum of every six (6) months to review and update the plan of care (POC) as necessary.
- B. PPEC services include, but are not limited to:
1. Nursing services,
  2. Respiratory therapy,

3. Developmental services,
4. Nutrition services,
5. Social services,
6. Physical therapy, occupational therapy and/or speech-language pathology,
7. Durable medical equipment and medical supplies as required by the Mississippi Department of Health (MSDH), and
8. Transportation to and from the PPEC facility unless the beneficiary's parent and/or legal guardian chooses for the beneficiary to be transported by a family member or friend.

C. All PPEC services must meet the MSDH's minimum standards in order to be covered.

Source: 42 U.S.C § 1396d; Miss. Code Ann. §§ 41-125-19, 43-13-117, 43-13-121.

History: Revised to correspond with SPA 19-0002 (eff. 01/01/2020), eff. 02/01/2020.

*Rule 3.4: Non-covered Services*

The Division of Medicaid does not cover the following as prescribed pediatric extended care (PPEC) services:

- A. Services that are not part of a written plan of care,
- B. Services that have not been ordered by a physician,
- C. Educational services,
- D. Services provided to beneficiaries that are related to the owner or operator by blood, marriage or adoption, and
- E. Services that do not meet the Mississippi Department of Health's (MSDH's) minimum standards.

Source: 42 U.S.C § 1396d; Miss. Code Ann. §§ 41-125-19, 43-13-117, 43-13-121.

History: Revised to correspond with SPA 19-0002 (eff. 01/01/2020), eff. 02/01/2020.

*Rule 3.5: Reimbursement*

- A. The Division of Medicaid reimburses up to twelve (12) hours per day of medically necessary prescribed pediatric extended care (PPEC) services for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) eligible beneficiaries when:

1. Ordered by the beneficiary's attending physician,
  2. Provided by a Mississippi licensed and Medicaid enrolled PPEC center, and
  3. Prior authorized by the Division of Medicaid or designee every six (6) months.
- B. The Division of Medicaid reimburses the lesser of the provider's usual and customary charge or:
1. An hourly rate for each complete hour of PPEC services for the first six (6) complete hours of PPEC services,
  2. A daily rate for over six (6) hours of PPEC services, and
  3. A daily rate for transportation to and from the PPEC center when provided by the PPEC.
- C. The following items and services are not included in the hourly or daily rates for PPEC services and must be billed separately by the rendering provider:
1. Occupational therapy,
  2. Physical therapy, and
  3. Speech-language pathology.
  4. Baby food or formula,
  5. Total parenteral and enteral nutrition,
  6. Mental health and/or psychiatric services, and
  7. Durable medical equipment (DME) and medical supplies.

Source: 42 C.F.R Part 441, Subpart B; Miss. Code Ann. §§ 41-125-19, 43-13-117, 43-13-121.

History: Revised to correspond with SPA 19-0002 (eff. 01/01/2020), eff. 02/01/2020.

*Rule 3.6: Documentation*

- A. Providers must maintain required documentation in accordance with Miss. Admin. Code Part 200, Rule 1.3, and must maintain auditable records to substantiate claims submitted to the Division of Medicaid or designated entity.
- B. Documentation must include, but is not limited to:

1. The physician's orders and any changes in physician orders,
2. Progress notes,
3. Prior authorization,
4. The plan of care and quarterly updates,
5. Immunization records,
6. Dates and times of all services provided including, but not limited to:
  - a) Medication administration record,
  - b) Treatment administration record, and
  - c) Respiratory treatment record
7. Dates and times of educational services,
8. Dietary orders,
9. Pick-up and drop-off times,
10. Accident reports,
11. Incident Reports, and
12. Emergency contact information.

C. Medical records must be available to the Division of Medicaid and/or designated entity upon request. [Refer to Maintenance of Records Part 200, Rule 1.3]

Source: 42 C.F.R Part 441, Subpart B; Miss. Code Ann. §§ 41-125-19, 43-13-117, 43-13-121.

History: Revised to correspond with SPA 19-0002 (eff. 01/01/2020), eff. 02/01/2020.

## **Chapter 4: Private Duty Nursing**

### *Rule 4.1: Definitions*

The Division of Medicaid defines:

- A. A medically necessary early and periodic screening, diagnosis and treatment (EPSDT) service as a service necessary to correct or ameliorate the individual child's physical or

mental condition with the determination made on a case-by-case basis taking into account the particular needs of the child.

- B. EPSDT-eligible beneficiary as a beneficiary who meets the requirements of the federally mandated EPSDT program.
- C. Private duty nursing (PDN) as skilled nursing care services for EPSDT-eligible beneficiaries who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of a hospital or skilled nursing facility.
- D. Skilled nursing care as a service requiring high-level skills of a registered nurse (RN) or licensed practical nurse (LPN) to provide curative, restorative, and preventative care. These services are rendered under the supervision of an RN and according to a plan of care and treatment created in consultation with the beneficiary's care team and approved by the beneficiary's physician.

Source: 42 U.S.C. §1396d; 42 C.F.R. Part 441; 42 C.F.R. § 440.80; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: New eff. 07/01/2020.

*Rule 4.2: Provider Requirements*

- A. Private duty nursing (PDN) providers must:
  - 1. Have a Division of Medicaid approved PDN Supplemental Provider Enrollment Packet.
  - 2. Establish a provider agreement with the Mississippi Division of Medicaid.
  - 3. Satisfy all requirements in accordance with Part 200, Rule 4.8 and must provide to the Division of Medicaid:
    - a) A National Provider Identifier (NPI) verification from National Plan and Provider Enumeration System (NPPES), and
    - b) Written confirmation from the Internal Revenue Service (IRS) confirming the provider's tax identification number and legal business name,
  - 4. Operate from a business office that is a dedicated professional location and not part of a residence,
  - 5. Disclose ownership information,
  - 6. Maintain auditable medical records on each beneficiary in the provider's business location, and



7. Maintain the highest level of ethical standard in its business practices and adopt written standard of ethical practice, which must include:
  - a) Neither the owner nor any PDN provider employee shall knowingly mislead a patient, family member or caretaker concerning services, charges, or use of equipment.
  - b) Neither the owner nor any PDN provider employee shall misuse or misappropriate any property-real or personal-belonging to any patient, family member or caretaker.
  - c) Neither the owner nor any PDN provider employee shall knowingly and actively recruit a patient under the care of another PDN provider.
  - d) No employee or patient of a PDN provider shall be coerced into participating in provider fund raising activities.
  - e) The PDN provider shall accept patient referrals in a professional manner with no remuneration provided to the referring party.
  - f) Patient clinical records, administrative records, and financial records shall not be falsified by any individual for any reason.

B. PDN providers must, at a minimum:

1. Conduct licensure checks with the Mississippi Board of Nursing, prior to employment and yearly thereafter.
2. Conduct background and abuse registry checks including,
  - a) National criminal background check with fingerprints, including review of both state and federal databases, on all employees or volunteers prior to employment and every two (2) years thereafter, and maintain the record of the checks in the employee's personnel file.
  - b) Conduct registry checks, prior to employment and monthly thereafter, to ensure employees are not listed on the Mississippi Nurse Aide Abuse Registry or listed on the Office of Inspector General's Exclusion Database and maintain the record of the checks in the employee's personnel file.
3. Not have been convicted of or pleaded guilty or nolo contendere to a felony of possession or sale of drugs, murder, manslaughter, armed robbery, rape, sexual battery, any sex offense listed in Miss. Code Ann. § 45-33-23(f), child abuse, arson, grand larceny, burglary, gratification of lust, aggravated assault, or felonious abuse and/or battery of a vulnerable adult, or that any such conviction or plea was reversed on appeal or a pardon was granted for the conviction or plea.
4. Not employ individuals or volunteers who have been, convicted of or pleaded guilty or

nolo contendere to a felony of possession or sale of drugs, murder, manslaughter, armed robbery, rape, sexual battery, any sex offense listed in Miss. Code Ann. § 45-33-23(f), child abuse, arson, grand larceny, burglary, gratification of lust, aggravated assault, or felonious abuse and/or battery of a vulnerable adult, or that any such conviction or plea was reversed on appeal or a pardon was granted for the conviction or plea.

5. Provide each employee a thorough orientation to their position, the provider, policies and objectives, the functions of other personnel and how they relate to each other in caring for the beneficiary, standards of ethical practice, confidentiality and patient's rights. All PDN providers must comply with the Centers for Disease Control and/or the Mississippi Department of Health regarding baseline and routine employee TB testing and education.
6. Provide mandatory annual in-service to RNs and LPNs including, but not limited to:
  - a) Beneficiary's rights,
  - b) Requirements to report suspected abuse, neglect, or exploitation immediately and how to report to the appropriate authority,
  - c) Requirements under Health Insurance Portability and Accountability Act (HIPAA) of 1996 and other relevant laws affecting privacy,
  - d) Infection control, and
  - e) Emergency procedures.
7. Ensure Full-time and part-time nurses employed by the PDN provider complete a minimum of twelve (12) hours of pertinent continuing education programs per year.
8. Employ a supervising RN who does not provide direct patient care and must:
  - a) Conduct a home evaluation visit prior to the initiation of services in the primary residence,
  - b) Complete the plan of care (POC) and revise as needed,
  - c) Initiate appropriate preventive and rehabilitative nursing procedures,
  - d) Inform the primary care physician of any changes in the beneficiary's condition and needs when appropriate,
  - e) Assign nurses to provide PDN services according to their licensure training, and level of experience,
  - f) Make a supervisory home visit at least:

- (1) Monthly with the servicing LPN present, and
  - (2) Every other week with the servicing CNA alternately present and absent.
- g) Document the following during the supervisory visit:
- 1) PDN services are provided according to the plan of care,
  - 2) The beneficiary's and/or beneficiary representative's satisfaction level with the PDN services, and
  - 3) That the plan of care has been reviewed and updated with the most current physician's orders.
- h) Make a home visit in addition to the monthly visit when:
- 1) The beneficiary's condition has changed,
  - 2) The beneficiary's health, safety, or welfare is potentially at risk, and
  - 3) Requested by the Division of Medicaid or designee.
- i) Make a monthly telephone contact with the beneficiary's guardian or legal representative to ensure satisfaction with services provided.
- h) Use a person-centered approach to PDN services and ensure personal goals of the beneficiary are respected,
- i) Ensure freedom of choice of providers and/or services is given to the beneficiary, the beneficiary's guardian or legal representative as long as the provider is not an immediate family member or a resident of the beneficiary's home,
- j) Educate the beneficiary and family/caregiver(s) in meeting nursing and related goals,
- k) Ensure services are provided in a manner that is in the best interest of the beneficiary and does not endanger the beneficiary's health, safety, or welfare;
- l) Recommend staff changes when needed,
- m) Report to the Division of Medicaid any unethical or incompetent practices that jeopardize public safety or cause a risk of harm to beneficiaries, including household issues that may jeopardize the safety of the PDN, and
- n) Ensure that all nurses and caregivers are aware that timesheets must be accurate with arrival and departure time of the nurse.

9. Ensure that an emergency preparedness plan is in place for each beneficiary receiving services,
10. Ensure that no immediate family member or person residing in the home with the beneficiary is providing PDN services submitted for Medicaid reimbursement,

C. An RN or LPN providing PDN services must:

1. Be employed by a Mississippi Medicaid enrolled PDN provider,
2. Maintain a current Mississippi nursing license, and
3. Practice within the scope of their license, and
4. Have at least one (1) year of experience providing the type of care required by the beneficiary's medical needs.

D. PDN providers must provide beneficiaries a written notice at least thirty (30) days prior to the discontinuation of services or closure of the PDN provider except when the requirements of Miss. Admin. Code Title 23, Part 223, Rule 3.5.C. are met.

1. PDN providers must assist with the beneficiary's transition to another provider.
2. PDN providers who fail to provide proper written notice will not be reimbursed for services provided during the thirty (30) day period the beneficiary should have been notified.

E. PDN providers must require all employees to report incidents and/or accidents that result or could have resulted in harm to the beneficiary and/or employee to the direct supervisor immediately and to the Division of Medicaid within twenty-four (24) hours.

F. All PDN providers and their employees must immediately report in writing to the Division of Medicaid Office of Medical Services, the Mississippi Department of Human Services (MDHS), and any other entity required by federal or state law, all alleged or reported instances the following:

1. Abuse,
2. Neglect,
3. Exploitation,
4. Suspicious death, or
5. Unauthorized use of restraints, seclusion or restrictive interventions.

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

History: Revised eff. 12/01/2020; New eff. 07/01/2020.

*Rule 4.3: Covered Services*

- A. The Division of Medicaid covers medically necessary private duty nursing (PDN) services only for early and periodic screening, diagnosis and treatment (EPSDT)-eligible beneficiaries when:
1. Ordered and directed by the beneficiary's primary physician or appropriate physician specialist.
  2. Prior authorized by the Division of Medicaid or designee.
  3. The required service(s) exceed the level of services provided through the home health benefit.
  4. Post-acute inpatient skilled nursing care is not appropriate, does not meet the beneficiary's care needs, or is not available.
  5. Provided in a setting in which the beneficiary's normal life activities take place.
  6. All medical and home environment criteria are met.
  7. Are directly related to the beneficiary's illness or disability.
  8. Services can be safely provided by only one (1) nurse and do not require the assistance of a second (2<sup>nd</sup>) nurse.
  9. The plan of care (POC) includes multiple skilled nursing functions and is not limited to just one (1) skilled nursing function, such as for the administration of a nasogastric or gastrostomy feeding.
  10. The beneficiary:
    - a) Is medically stable to receive nursing care managed safely in a non-institutional setting where normal life activities take place,
    - b) Has a documented illness or disability of such severity and/or complexity that it requires prescribed care that can only be provided by an RN or LPN, and
    - c) Requires more individual and continuous care than is available from a visiting nurse through intermittent home health care or custodial care.
  11. The home environment is conducive to appropriate growth and development for the

beneficiary's age group and is conducive to the provision of appropriate medical care.

12. There must be at least one (1) parent or other caregiver capable of and willing to be trained to assist in the provision of care for the beneficiary and the parent or caregiver must:

a) Provide evidence of parental or family involvement, and an appropriate home situation including, but not limited to, a physical environment and geographic location for the beneficiary's medical safety.

b) Have a reasonable plan for an emergency situation including, but not limited to:

1) Power and equipment backup for those with a life-support device,

2) Access to a working telephone, and

3) Available transportation adequate to safely transport the beneficiary.

c) Comply with the plan of care, physician office appointments and/or other ancillary services.

B. The level of care required to meet the beneficiary's needs is determined by the referring physician.

C. PDN services are covered only when provided:

1. By an RN or LPN:

a) With a current Mississippi license acting within the scope-of-practice, and

b) Employed by a PDN provider,

2. Under the direction of the beneficiary's physician, and

3. In a non-institutional setting where normal life activities take place.

D. PDN services are covered:

1. On short-term basis for beneficiaries in need of parent and/or caregiver training in order to reside in the home and community, or

2. On a long-term basis for beneficiaries that require substantial and complex care that exceeds the level of service available from the home health benefit in order to remain in the home and community setting.

Source: 42 C.F.R. § 440.80; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: New eff. 07/01/2020.

*Rule 4.4: Prior Authorization and Concurrent Reviews*

- A. Private duty nursing (PDN) providers must submit a prior authorization request to the Division of Medicaid or designee prior to the initiation of PDN services which must include, at a minimum, the following:
1. A signed physician or specialist's order for PDN and a signed initial Plan of Care (POC),
  2. Beneficiary diagnosis(es),
  3. Skilled teaching/instructions to be provided to a family member or caregiver(s),
  4. Treatment plan/physician orders specifying each skill to be performed including whether the service(s) require a registered nurse (RN) or a licensed practical nurse (LPN),
  5. Expected duration of service,
  6. Identification of any other home care services, including the hours, days, and times of these services being provided, including, but limited to:
    - a) Case management,
    - b) Physical therapy,
    - c) Speech therapy,
    - d) Occupational therapy,
    - e) Respiratory therapy,
    - f) Respite,
    - g) Hospice, and/or
    - h) Personal care attendant.
  7. When PDN medical necessity criteria are no longer met, a plan:
    - a) For reducing and discontinuing PDN hours, and
    - b) To transition the beneficiary to the most appropriate setting.

- B. The PDN provider must submit a recertification of PDN services, every six (6) months indicating the number of hours per day or week and the duration of the request to the Division of Medicaid, or designee and include the following:
  - 1. An updated POC,
  - 2. Progress notes,
  - 3. Monthly summaries, and
  - 4. Nursing visit notes.
- C. The PDN provider cannot bill the beneficiary for hours when the provider failed to seek certification/recertification in a timely manner.

Source: 42 C.F.R. § 440.80; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: New eff. 07/01/2020.

*Rule 4.5: Discontinuation of Private Duty Nursing (PDN) Services*

Private duty nursing (PDN) services will be discontinued when one (1) or more of the following is met:

- A. When all of the following exist:
  - 1. Beneficiary's condition is clinically stable,
  - 2. The licensed nurses' skills are not required to provide ongoing nursing assessment and/or treatment,
  - 3. Beneficiary demonstrates the ability to carry out self-management,
  - 4. Caregiver(s) demonstrates the ability to carry out management of the beneficiary's condition, and
  - 5. When the transition is complete.
- B. The beneficiary's care and needs can be met through custodial care.
- C. When home-based care is unsafe and:
  - 1. The PDN provider immediately reports the unsafe environment or imminent danger to the beneficiary, caregiver or provider to the Division of Medicaid, the beneficiary's physician and all appropriate authorities including, but not limited to:



- a) Local law enforcement,
  - b) The Mississippi Department of Child Protection Services, and/or
  - c) Other appropriate authorities designated in state or federal law.
2. The PDN provider has assisted the beneficiary in transitioning to a safe environment to the extent possible without endangering the beneficiary, caregiver or service provider.
  3. The PDN provider has made every effort to transition the beneficiary to a safer environment.

Source: 42 C.F.R. § 440.80; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: New eff. 07/01/2020.

*Rule 4.6: Non-Covered Services*

- A. The Division of Medicaid does not cover private duty nursing (PDN) services solely for the convenience of the child, the parents or the caregiver.
- B. Non-covered PDN services include, but are not limited to:
  1. PDN services solely for:
    - a) Nasogastric or gastrostomy feedings,
    - b) Apnea monitoring,
    - c) Home dialysis,
    - d) Intravenous (IV) infusion of total parenteral nutrition (TPN) or hyperalimentation,
    - e) IV infusion of fluids for hydration or,
    - f) Therapy maintenance.
  2. PDN services provided by those individuals described in Miss. Admin. Code Part 200, Rule 2.2.A.,
  3. For the sole purpose of escorting beneficiaries outside of the home for visits to a physician's office or school, and/or
  4. Skilled nursing services which could be provided through the home health benefit.

- C. Only one (1) service is covered if PDN and personal care services (PCS) are provided at the same time to the same beneficiary.

Source: 42 C.F.R. § 440.80; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: New Rule eff. 07/01/2020.

*Rule 4.7: Denial of Services and Appeals*

- A. The Division of Medicaid or designee will issue a written denial to the private duty nursing (PDN) provider providing PDN services when the beneficiary no longer meets the medical and/or home environment criteria for PDN services.
- B. The denial of services is effective thirty (30) days following the date the provider receives the written decision.
- C. The beneficiary has the right to request an administrative hearing if he/she disagrees with the denial. [Refer to Miss. Admin. Code Part 300, Rule 1.3]

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

History: New eff. 07/01/2020.

*Rule 4.8: Reimbursement*

[Reserved]

*Rule 4.9: Documentation Requirements*

- A. Nurses providing private duty nursing (PDN) services must document all nursing care rendered during each shift including, but not limited to:
  - 1. Current physician's orders,
  - 2. Medications administered and response,
  - 3. Treatments administered and response,
  - 4. Any other professional nursing skills provided during the shift,
  - 5. Narrative skilled nursing services notes including accurate dates and times of services and documentation that a copy was given to parent and/or legal guardian or caregiver, and
  - 6. Any significant changes in the beneficiary's condition,

- B. Weekly timesheets must be maintained for each nurse providing PDN services that include:
1. The date the services were provided,
  2. Begin and end times of services and a list of services provided during that time,
  3. The dated signature of the nurse, and
  4. The dated signature of the beneficiary's guardian or legal representative.
- C. The PDN provider must establish and maintain a permanent, legible medical record for each beneficiary at the provider's office which must include, at a minimum, the following:
1. Physician orders updated and signed by the physician every six (6) months,
  2. Current physician's treatment plan updated every six (6) months,
  3. Nursing plan of care (POC) based on the diagnosis(es), clinical and social status of the beneficiary including measurable goals updated every six (6) months,
  4. Documentation of changes in clinical status and/or significant occurrences,
  5. Weekly progress notes,
  6. Monthly summaries must include the following, at a minimum:
    - a) Nursing skills provided,
    - b) Progress or lack of progress toward goals,
    - c) Clinical and social status of the beneficiary,
    - d) Current medications and treatments and changes made during the month, and
    - e) Changes in the POC.
  7. Information regarding other home care services being provided to the beneficiary including:
    - a) The specific services provided,
    - b) Date and times of services, and
    - c) The providers of the services.
  8. Copies of all prior authorizations.

- D. All records must be maintained and retained in accordance with HIPPA and Medicaid regulations. [Refer to Part 200, Rule 1.3.]
- E. The Division of Medicaid will not reimburse PDN providers for both PDN and PCS services provided at the same time to the same beneficiary.

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

History: New eff. 07/01/2020.

## **Chapter 5: Personal Care Services**

### *Rule 5.1: Definitions*

The Division of Medicaid defines:

- A. A medically necessary early and periodic screening, diagnosis and treatment (EPSDT) service as a service necessary to correct or ameliorate the individual child's physical or mental condition with the determination made on a case-by-case basis taking into account the particular needs of the child.
- B. EPSDT-eligible beneficiary as a beneficiary who meets the requirements of the federally mandated EPSDT program.
- C. Personal care services (PCS) as medically necessary personal care services for EPSDT-eligible beneficiaries who require assistance in order to safely perform the activities of daily living (ADLs) due to a diagnosed condition, disability, or injury. The delivery and receipt of these services must be medically necessary for the treatment of the beneficiary's condition, disability, or injury and exceed the level of care available through the home health benefit..
- D. Certified Nurse Assistant (CNA) as an individual who obtained certification through a program approved by the Mississippi Department of Health, Licensure and Certification. CNAs are the only individuals who may render personal care services. These services must be delivered under the supervision of a registered nurse (RN) pursuant to the plan of treatment established in consultation with appropriate members of the care team under the direction of the beneficiary's physician.

Source: 42 U.S.C. §1396d; 42 C.F.R. Part 441; 42 C.F.R. § 440.167; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: New Rule eff. 07/01/2020.

### *Rule 5.2: Provider Requirements*

- A. Certified Nursing Assistants (CNAs) providing personal care services (PCS) must be hired and managed by private duty nursing (PDN) providers. PDN providers employing CNAs must:
1. Enter into a provider agreement with the Mississippi Division of Medicaid.
  2. Satisfy all requirements set forth in Part 200, Rule 4.8 and must provide to the Division of Medicaid:
    - a) A National Provider Identifier (NPI) verification from National Plan and Provider Enumeration System (NPPES), and
    - b) Written confirmation from the Internal Revenue Service (IRS) confirming the provider's tax identification number and legal business name,
  3. Operate from a business office that is a dedicated professional location and not part of a residence,
  4. Disclose ownership information, and
  5. Maintain auditable medical records on each beneficiary in the provider's business location.
- B. PDN providers employing CNAs must, at a minimum:
1. Conduct certification checks prior to employment and yearly thereafter.
  2. Conduct background and abuse registry checks including,
    - a) National criminal background check with fingerprints on all employees or volunteers prior to employment and every two (2) years thereafter, and maintain the record of the checks in the employee's personnel file.
    - b) Conduct registry checks, prior to employment and monthly thereafter, to ensure employees are not listed on the Mississippi Nurse Aide Abuse Registry or listed on the Office of Inspector General's Exclusion Database and maintain the record of the checks in the employee's personnel file.
  3. Not have been convicted of or pleaded guilty or nolo contendere to a felony of possession or sale of drugs, murder, manslaughter, armed robbery, rape, sexual battery, any sex offense listed in Miss. Code Ann. § 45-33-23(f), child abuse, arson, grand larceny, burglary, gratification of lust, aggravated assault, or felonious abuse and/or battery of a vulnerable adult, or that any such conviction or plea was reversed on appeal or a pardon was granted for the conviction or plea.
  4. Not employ individuals or volunteers who have been convicted of or pleaded guilty or

nolo contendere to a felony of possession or sale of drugs, murder, manslaughter, armed robbery, rape, sexual battery, any sex offense listed in Miss. Code Ann. § 45-33-23(f), child abuse, arson, grand larceny, burglary, gratification of lust, aggravated assault, or felonious abuse and/or battery of a vulnerable adult, or that any such conviction or plea was reversed on appeal or a pardon was granted for the conviction or plea.

5. Provide mandatory annual in-service to CNAs including, but not limited to:
  - a) Beneficiary's rights, including but not limited to rights protected by HIPPA,
  - b) Requirements to report suspected abuse, neglect, or exploitation immediately and how to report to the appropriate authority,
  - c) Requirements under Health Insurance Portability and Accountability Act (HIPAA) of 1996 and other relevant laws affecting privacy,
  - d) Infection control, and
  - e) Emergency procedures.
  
6. Employ a supervising registered nurse (RN) who does not provide direct patient care and must:
  - a) Conduct an initial evaluation visit prior to the initiation of services in the primary residence,
  - b) Complete the plan of care (POC) and revise as needed,
  - c) Initiate appropriate preventive and rehabilitative procedures,
  - d) Inform the primary care physician of any changes in the beneficiary's condition and needs when appropriate,
  - e) Assign CNAs to provide PCS according to their certification, training, and level of experience,
  - f) Make a supervisory visit at least every other week with the servicing RN, LPN, or CNA alternately present and absent and document the following:
    - 1) PCS services are provided according to the plan of care,
    - 2) The beneficiary's and/or beneficiary representative's satisfaction level with the PCS services, and
    - 3) That the plan of care has been reviewed and updated with the most current physician's orders.

- g) Make a home visit in addition to the monthly visit when:
    - 1) The beneficiary's condition has changed,
    - 2) The beneficiary's health, safety, or welfare is potentially at risk, and/or
    - 3) Requested by the Division of Medicaid or designee.
  - h) Use a person-centered approach to PCS and ensure personal goals of the beneficiary are respected,
  - i) Ensure freedom of choice of providers and/or services is given to the beneficiary, the beneficiary's guardian or legal representative as long as the provider is not an immediate family member or a resident of the beneficiary's home,
  - j) Educate the beneficiary and family/caregiver(s) in meeting PCS and related goals,
  - k) Ensure services are provided in a manner that is in the best interest of the beneficiary and does not endanger the beneficiary's health, safety, or welfare;
  - l) Recommend staff changes when needed,
  - m) Report to the Division of Medicaid any unethical or incompetent practices that jeopardize public safety or cause a risk of harm to beneficiaries, including household issues that may jeopardize the safety of the CNA, and
  - n) Ensure that all CNAs and caregivers are aware that timesheets must be accurate with arrival and departure time of the CNA.
7. Ensure that an emergency preparedness plan is in place for each beneficiary receiving services,
  8. Ensure that no immediate family member or person residing in the home with the beneficiary is providing PCS submitted for Medicaid reimbursement,
  9. Ensure certified nursing assistants employed by the PDN provider complete a minimum of twelve (12) hours of pertinent continuing education programs per year.

C. A CNA providing PCS must:

1. Be employed by a Mississippi Medicaid enrolled PDN provider that is approved to provide CNAs,
2. Maintain a current Mississippi certification as required to be a CNA per Rule 4.1.D of this chapter, and

3. Practice within the scope of their certification and training.
- D. Effective January 1, 2021, all PDN providers providing PCS services must utilize a Mississippi Medicaid approved Electronic Visit Verification (EVV) system for the submission of claims. Approved EVV systems must include the:
1. Type of service performed,
  2. Individual receiving the services,
  3. Date of the service,
  4. Location of the services,
  5. Individual providing the service, and
  6. Time the services begins and ends.
- E. PDN providers must provide beneficiaries a written notice at least thirty (30) days prior to the discontinuation of services or closure of the PDN provider except when the requirements of Miss. Admin. Code Title 23, Part 223, Rule 3.5.C. are met.
1. PDN providers must assist with the beneficiary's transition to another provider.
  2. PDN providers who fail to provide proper written notice will not be reimbursed for services provided during the thirty (30) day period the beneficiary should have been notified.

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

History: Revised eff. 12/01/2020; New Rule eff. 07/01/2020.

*Rule 5.3: Covered Services*

- A. The Division of Medicaid covers medically necessary personal care services (PCS) only for early and periodic screening, diagnosis and treatment (EPSDT)-eligible beneficiaries when:
1. Ordered and directed by the beneficiary's primary physician or appropriate physician specialist.
  2. Prior authorized by the Division of Medicaid or designee.
  3. The required service(s) exceed the level of services provided through the home health benefit.



4. Provided in a setting in which the beneficiary's normal life activities take place.
  5. All medical and home environment criteria are met.
  6. Are directly related to the beneficiary's illness or disability.
  7. Services can be safely provided by only one (1) Certified Nursing Assistant (CNA) and do not require the assistance of a second (2<sup>nd</sup>) CNA.
  8. The beneficiary:
    - a) Is medically stable to receive PCS managed safely in a non-institutional setting where normal life activities take place,
    - b) Has a documented illness or disability that requires the assistance of a CNA in order to safely perform activities of daily living, and
    - c) Requires more individual and continuous care than is available from a visiting CNA through intermittent home health care.
  9. The home environment is conducive to appropriate growth and development for the beneficiary's age group and be conducive to the provision of appropriate medical care.
  10. There must be at least one (1) parent or other caregiver capable of and willing to be trained to assist in the provision of care for the beneficiary and the parent or caregiver must:
    - a) Provide evidence of parental or family involvement and an appropriate home situation including, but not limited to, a physical environment and geographic location for the beneficiary's medical safety.
    - b) Have a reasonable plan for an emergency situation including, but not limited to:
      - 1) Power and equipment backup for equipment necessary to the medical care of the beneficiary,
      - 2) Access to a working telephone, and
      - 3) Available transportation adequate to safely transport the beneficiary.
    - c) Comply with the plan of care, physician office appointments and/or other ancillary services.
- B. The level of care required to meet the beneficiary's needs is determined by the referring physician.

C. PCS services are covered only when provided:

1. By a CNA:
  - a) With a current Mississippi certification,
  - b) Employed by a private duty nursing (PDN) provider that is approved by the Division of Medicaid to provide CNAs, and
  - c) Have at least one (1) year of experience providing the type of care required by the beneficiary's medical condition.
2. Under the supervision of an RN and at the direction of the beneficiary's physician, and
3. In a non-institutional setting where normal life activities take place.

D. PCS are covered:

1. On short-term basis for beneficiaries in need of parent and/or caregiver training in order to reside in the home and community, or
2. On a long-term basis for beneficiaries that require substantial and complex care that exceeds the level of service available from the home health benefit in order to remain in the home and community setting.

Source: 42 C.F.R. § 440.167; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: New Rule eff. 07/01/2020.

*Rule 5.4: Prior Authorization and Concurrent Reviews*

- A. Private duty nursing (PDN) providers employing Certified Nursing Assistants (CNAs) must submit a prior authorization request to the Division of Medicaid or designee at least two (2) weeks prior to the initiation of personal care services (PCS) that must include, at a minimum, the following:
1. A signed physician or specialist's order for PCS and a signed initial Plan of Care (POC),
  2. Beneficiary diagnosis(es),
  3. Skilled teaching/instructions to be provided to a family member or caregiver(s),
  4. Treatment plan/physician orders specifying each skill to be performed,
  5. Expected duration of service,

6. Identification of any other home care services, including the hours, days, and times of these services being provided, including, but limited to:
    - a) Case management,
    - b) Physical therapy,
    - c) Speech therapy,
    - d) Occupational therapy,
    - e) Respiratory therapy,
    - f) Respite,
    - g) Hospice, and/or
    - h) Private duty nursing.
  7. When PCS medical necessity criteria are no longer met, a plan:
    - a) For reducing and discontinuing PCS hours, and
    - b) To transition the beneficiary to the most appropriate setting.
- B. A PDN provider employing a CNA must submit a recertification to the Division of Medicaid or designee stating the necessity of PCS for each subject beneficiary every six (6) months indicating the number of hours per day or week and the duration of the request and include the following:
1. An updated POC,
  2. Progress notes,
  3. Monthly summaries, and
  4. Supervisory nursing visit notes.
- C. If the required recertification information is not received before the last certified date, the hours from the last certification period up until the date of receipt of the required documentation are subject to denial.
- D. A PDN provider employing CNAs cannot bill the beneficiary for hours when the provider failed to seek certification/recertification in a timely manner.

Source: 42 C.F.R. § 440.167; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: New eff. 07/01/2020.

*Rule 5.5: Discontinuation of Personal Care Services (PCS)*

Personal care services (PCS) will be discontinued when one (1) or more of the following is met:

A. When all of the following exist:

1. Beneficiary's condition is clinically stable,
2. The Certified Nursing Assistant (CNA) skills are not required to provide assistance with activities of daily living,
3. Beneficiary demonstrates the ability to carry out self-management,
4. Caregiver(s) demonstrates the ability to carry out management of the beneficiary's condition, and
5. When the transition is complete.

B. The beneficiary's care and needs can be met through custodial care.

C. When home-based care is unsafe and:

1. The PCS provider immediately reports the unsafe environment or imminent danger to the beneficiary, caregiver or provider to the Division of Medicaid, the beneficiary's physician and all appropriate authorities including, but not limited to:
  - a) Local law enforcement,
  - b) The Mississippi Department of Child Protection Services, and/or
  - c) Other appropriate authorities designated in state or federal law.
2. The PCS provider has assisted the beneficiary in transitioning to a safe environment to the extent possible without endangering the beneficiary, caregiver or service provider.
3. The PCS provider has made every effort to transition the beneficiary to a safer environment.

Source: 42 C.F.R. § 440.167; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: New Rule eff. 07/01/2020.

*Rule 5.6: Non-Covered Services*

- A. The Division of Medicaid does not cover personal care services (PCS) solely for the convenience of the child, the parents or the caregiver.
- B. Non-covered PCS include, but are not limited to:
  - 1. Skilled nursing services including, but not limited to:
    - a) Nasogastric or gastrostomy feedings,
    - b) Apnea monitoring,
    - c) Home dialysis,
    - d) Intravenous (IV) infusion of total parenteral nutrition (TPN) or hyperalimentation,
    - e) IV infusion of fluids for hydration
    - f) Medication administration, and/or
    - g) Tracheostomy care.
  - 2. Services provided by those individuals described in Miss. Admin. Code Part 200, Rule 2.2.A.,
  - 3. For the sole purpose of escorting beneficiaries outside of the home for visits to a physician's office or school, and/or
  - 4. Services that could be provided through the home health benefit.
- C. Only one (1) service is covered if private duty nursing (PDN) and PCS are provided at the same time to the same beneficiary.

Source: 42 C.F.R. § 440.167; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: New Rule eff. 07/01/2020.

*Rule 5.7: Denial of Services and Appeals*

- A. The Division of Medicaid or designee will issue a written denial to the private duty nursing (PDN) provider employing the Certified Nursing Assistant (CNA) when the beneficiary no longer meets the medical and/or home environment criteria for personal care services.
- B. The denial of services is effective thirty (30) days following the date the provider receives the written decision.

- C. The beneficiary has the right to request an administrative hearing if he/she disagrees with the denial. [Refer to Miss. Admin. Code Part 300, Rule 1.3]

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

History: New Rule eff. 07/01/2020.

*Rule 5.8: Reimbursement*

[Reserved]

*Rule 5.9: Documentation Requirements*

- A. Certified Nursing Assistants (CNAs) providing personal care services (PCS) must document all care rendered during each shift including, but not limited to:
1. Assistance with activities of daily living (ADL), and
  2. Any significant changes in the beneficiary's condition.
- B. Weekly timesheets must be maintained for each CNA providing PCS that include:
1. The date the services were provided,
  2. Begin and end times of services and a list of services provided during that time,
  3. The dated signature of the CNA, and
  4. The dated signature of the beneficiary's guardian or legal representative.
- C. The PDN provider must establish and maintain a permanent, legible medical record for each beneficiary at the provider's office which must include, at a minimum, the following:
1. Physician orders updated and signed by the physician every six (6) months,
  2. Current physician's treatment plan updated every six (6) months,
  3. Plan of care (POC) based on the diagnosis(es), clinical and social status of the beneficiary including measurable goals updated every six (6) months,
  4. Documentation of changes in clinical status and/or significant occurrences,
  5. Weekly progress notes,
  6. Monthly summaries must include the following, at a minimum:

- a) CNA services provided,
  - b) Progress or lack of progress toward goals,
  - c) Clinical and social status of the beneficiary, and
  - e) Changes in the POC.
7. Information regarding other home care services being provided to the beneficiary including:
- a) The specific services provided,
  - b) Date and times of services, and
  - c) The providers of the services.
8. Copies of all prior authorizations.

D. All records must be maintained and retained in accordance with HIPPA and Medicaid regulations. [Refer to Part 200, Rule 1.3, Maintenance of Records.]

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

History: New Rule eff. 07/01/2020.

## **Chapter 6: Expanded Rehabilitative Services**

### *Rule 6.1: Definitions*

A. The Division of Medicaid defines:

1. Clinical/medical case record as the central repository of all pertinent information about the beneficiary that provides an accurate chronological accounting of the treatment plan and progress.
2. Day treatment as a behavioral intervention and strengths-based program, provided in the context of a therapeutic milieu, which enables beneficiaries between the ages of three (3) and twenty-one (21) with serious emotional disturbances or autism/Asperger's syndrome to live in the community.
3. A developmental evaluation as an assessment by a licensed practitioner utilizing standardized developmental instruments of the current cognitive, social and motor function of beneficiaries younger than three (3) years of age or beneficiaries with such severe mental or physical disabilities that a standardized intellectual assessment is not possible.

4. Duplication of services as the provision of the same service to the same beneficiary by the same or different provider on the same day.
5. Mississippi Youth Programs Around the Clock (MYPAC) services as home and community-based services for EPSDT-eligible beneficiaries with a serious emotional disturbance (SED) that meet the level of care provided in a psychiatric residential treatment facility (PRTF).
6. A neuropsychological evaluation as a performance-based method to assess cognitive functioning which includes the collection of diagnostic information, differential diagnostic information, assessment of treatment response, and prediction of functional potential and recovery potential.
7. Wraparound facilitation as the creation and facilitation of a child/youth and family team for the purpose of developing a single care plan to address the needs of children/youth with complex mental health challenges and their families.

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

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

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

*Rule 6.2: Provider Requirements*

- A. Providers of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Rehabilitative Services must comply with the provider requirements described in Miss. Admin. Code Title 23, Part 206, Rule 1.1.
- B. Providers employing any evidence-based practices (EBP) in the course of treatment must have completed the appropriate training for the specific EBP.
- C. Wraparound facilitators must be certified by the Mississippi Department of Mental Health (DMH).
- D. Mississippi Youth Programs Around the Clock (MYPAC) providers must comply with the requirements in Miss. Admin. Code Title 23, Part 200, Rule 4.8 and meet the following provider specific requirements:
  1. Submit a completed MYPAC project plan and enter into a provider agreement with the Division of Medicaid to become a MYPAC Medicaid Provider.
  2. Ensure services are provided by staff acting within their scope of practice and in accordance the DMH's requirements.



3. Have a current Medicaid provider number.
4. Hold certification by DMH to provide:
  - a) Wraparound facilitation services, and
  - b) Community Support services.
5. Have a psychiatrist on staff.
6. Have or have contracted with appropriate clinical staff to provide needed therapy services.
7. Notify the Division of Medicaid of changes in the Administrative/Program Director, Medical Director/Psychiatrist or Clinical Director, and Regional Supervisor within seventy-two (72) hours of the effective change.
8. Have written policies for documenting and reporting all critical incidents/occurrences which must include the following:
  - a) Reporting of critical incidents in writing within one (1) business day to the Division of Medicaid with staff intervention responses and management of the critical incident.
  - b) Reporting any suspected abuse or neglect to the Mississippi Department of Human Services (DHS) and participate in investigations.
  - c) A written description of all critical events and actions.
  - d) Documentation that explains follow-up, resolution, and debriefing.
9. Establish a grievance system that includes written policies and procedures.
  - a) Inform the beneficiary and family of the grievance and appeals policies and procedures.
  - b) Track and maintain record of all grievances and responses.
10. Have a written appeal process with policies and procedures which includes a Notice of Action.
  - a) Forward any formal appeal requests, including the Notice of Action, to the Division of Medicaid within two (2) business days of receipt,
  - b) Submit a quarterly report to the Division of Medicaid summarizing each appeal, either on-going or resolved, received during the quarter.

11. Participate, at the provider's sole expense, in any review, appeal, fair hearing or litigation involving issues related to MYPAC at the request of the Division of Medicaid.
12. Employ staff who meet the requirements in Miss. Admin. Code Title 23, Part 206 and DMH qualifications for the category of service they provide.
13. Conduct Quality Assurance activities to review each beneficiary's Wraparound Service Plan (WSP) and treatment outcomes.
14. Have the ability to provide face-to-face crisis response services twenty-four (24) hours per day, seven (7) days per week directly or through an arrangement with a crisis response team. Crisis response services may be provided in an emergency department of a hospital.

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

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

*Rule 6.3: Covered Services*

- A. All State Plan services described in Miss. Admin. Code Part 206 and Part 223 are covered for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)-eligible beneficiaries without regard to service limits when prior authorized by the Utilization Management/Quality Improvement Organization (UM/QIO).
- B. The Division of Medicaid covers neuropsychological evaluations for EPSDT-eligible beneficiaries when medically necessary, prior authorized by a UM/QIO, the Division of Medicaid or designee and conducted by a psychologist trained to administer, score and interpret neuropsychological instruments, and one (1) or more of the following apply:
  1. Other interventions have been unsuccessful with the beneficiary,
  2. Previous psychological evaluation indicates neuropsychological deficits and supports justification,
  3. The beneficiary displays evidence of cognitive deficits or brain injury, or
  4. Results are used in treatment planning and placement decisions.
- C. The Division of Medicaid covers developmental evaluations for EPSDT-eligible beneficiaries when medically necessary, prior authorized by a UM/QIO, the Division of Medicaid or designee, conducted by a physician or a psychologist with knowledge and expertise to administer and interpret developmental evaluation results and uses the results or the following:

1. To assist in treatment planning for a beneficiary less than three (3) years of age or a beneficiary with a severe disability, or
  2. To confirm the existence of a major diagnosis.
- D. The Division of Medicaid covers day treatment services for EPSDT eligible beneficiaries when the service and provider meet the following requirements:
1. Service components include:
    - a) Treatment plan development and review.
    - b) Skill building groups such as social skills training, self-esteem building, anger control, conflict resolution and daily living skills.
  2. Certified to operate by the Mississippi Department of Mental Health (DMH).
  3. Included in a care plan approved by one (1) of the following: a psychiatrist, physician, psychologist, psychiatric mental health nurse practitioner (PMHNP), physician assistant (PA), licensed clinical social worker (LCSW), licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), licensed medical social worker (LMSW) or certified mental health therapist (CMHT).
  4. Provided by a psychiatrist, physician, psychologist, PMHNP, PA, LCSW, LPC, LMFT, LMSW or CMHT.
  5. Prior authorized as medically necessary by the UM/QIO.
- D. The Division of Medicaid covers medically necessary wraparound facilitation services for EPSDT eligible beneficiaries when the service and provider meet the following requirements:
1. Service components include:
    - a) Engaging the family,
    - b) Assembling the beneficiary and family team which includes all of the required entities and individuals described in the DMH operational standards.
    - c) Facilitating the beneficiary and family team meeting, at a minimum, once every thirty (30) days,
    - d) Facilitating the development of a wraparound service plan (WSP) through decisions made by the beneficiary and family team during the beneficiary and

family team meeting, including a plan for anticipating, preventing and managing crisis,

- e) Working with the beneficiary and family team in identifying providers of services and other community resources to meet the family and beneficiary's needs,
- f) Making necessary referrals for beneficiaries,
- g) Documenting and maintaining all information regarding the WSP, including revisions and beneficiary and family team meetings,
- h) Presenting WSP for approval to the beneficiary and family team,
- i) Providing copies of the WSP to the entire team including the beneficiary and family/guardian,
- j) Monitoring the implementation of the WSP and revising as necessary to achieve outcomes,
- k) Maintaining communication between all beneficiary and family team members,
- l) Evaluating the progress toward needs being met to ensure the referral behaviors have decreased,
- m) Leading the beneficiary and family team to discuss and ensure the supports and services continue to meet the caregiver and the beneficiary's needs,
- n) Educating new team members about the wraparound process,
- o) Maintaining team cohesiveness,
- p) Meeting face-to-face with a MYPAC beneficiary once a week,
- q) Meeting face-to-face with the family twice a month,
- r) Meeting with other collateral contacts related to WSP implementation at least three (3) times a week, and
- s) Ensuring medication and management and monitoring of MYPAC beneficiaries on medication(s) used in the treatment of the beneficiary's Serious Emotional Disturbance (SED) occur at a physician visit every ninety (90) days at a minimum.

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

3. The ISP must be approved by one (1) of the following team members: a psychiatrist, physician, psychologist, PMHNP, PA, LCSW, LPC, or LMFT.
  4. Services are limited to two hundred (200) fifteen (15) minute units per state fiscal year.
- E. The Division of Medicaid covers Mississippi Youth Programs Around the Clock (MYPAC) services when prior authorized by the Division of Medicaid, UM/QIO, or designee for EPSDT-eligible beneficiaries that meet the following requirements:
1. The beneficiary must be diagnosed by a psychiatrist or psychologist with a mental, behavioral or emotional disorder of sufficient duration to meet the diagnostic criteria for Serious Emotional Disturbance (SED) specified within the most current Diagnostic and Statistical Manual (DSM),
  2. The beneficiary must be cognitively able to actively participate in the services recommended by the Wraparound Services Plan (WSP), or
  3. The beneficiary is currently a resident of a psychiatric residential treatment facility (PRTF) or acute care facility who continues to meet the level of care (LOC) for residential treatment but can be transitioned into the community with MYPAC services or meets the same LOC for admission to a PRTF but can be diverted to MYPAC as an alternative to residential treatment.
  4. Services include, but are not limited to:
    - a) Mental health services using evidence-based practices which include intensive in-home therapy, crisis outreach, medication management and psychiatric services,
    - b) Social services to ensure basic needs are met, provide family support, and develop age appropriate independent living skills.
    - c) Physical health and welfare services that include assistance to the family in obtaining screenings from the Early Periodic Screening, Diagnosis, and treatment (EPSDT) services.
    - d) Wraparound facilitation that complies with DMH Operating Standards.
  5. Development and implementation of an WSP.
    - a) The WSP must include the following:
      - (1) Services to be provided,
      - (2) Frequency of service provision,
      - (3) Staff providing each service and their qualifications,

- (4) Formal and informal supports available to the beneficiary and family, and
  - (5) Plans for anticipating, preventing and managing crises.
- b) Each WSP must include an Individualized Crisis Management Plan (ICMP) which:
- (1) Must be developed within one (1) day of admission to MYPAC services and updated when the comprehensive ICMP is developed during the first child and family team meeting.
  - (2) Identifies triggers that may lead to potential crisis or risk and interventions and strategies to avoid the crisis.
  - (3) Identifies natural supports that may decrease the potential for a crisis to occur.
  - (4) Identifies specific needs of families and tailors the level of intervention.
  - (5) Provides responses that are readily accessible at any time to the beneficiary and family.
  - (6) Contains contact information for those involved at all levels of intervention during the crisis.
  - (7) Provides for crisis debriefing after the crisis has been resolved.
  - (8) Provides initial and updated copies of the WSP, ICMP and contacts to the beneficiary and family.
- c) The wraparound facilitator must monitor the WSP continuously through face-to-face visits with the beneficiary and family.
- (1) The child and family team must review the WSP at least every thirty (30) days during a child and family team meeting.
  - (2) The WSP must be updated or revised when warranted by changes in the beneficiary's needs.
  - (3) The full child and family team must participate in the development of the initial WSP, revisions of the WSP, and the discharge WSP.
  - (4) A licensed clinical staff member must attend each child and family team meeting and is responsible for submitting the WSP to the psychiatrist for review following the meeting at least every ninety (90) days.

## 6. Discharge/Transition Planning

- a) Discharge planning must begin on the first day of admission and the MYPAC provider is responsible for assisting the family with transition plans through the wraparound process.
- b) Discharge from MYPAC services occurs when the beneficiary:
  - (1) Reaches twenty-two (22) years of age or “ages out”,
  - (2) Utilizes their freedom of choice to end MYPAC services, if applicable,
  - (3) Moves out of state,
  - (4) No longer meets the criteria or requires the level of care provided by MYPAC, or
  - (5) Is admitted to an acute care facility or PRTF.
- c) Discharge planning is done with the beneficiary and family through the wraparound process.
- d) At the time of the beneficiary’s discharge from MYPAC services, the discharge/transition plan must be amended to include any of the following, if there is a change:
  - (1) MYPAC services begin and end date,
  - (2) Reason for discharge,
  - (3) Name of the person or agency that cares for and has custody of the beneficiary,
  - (4) Physical location/address where the beneficiary resides,
  - (5) List of the beneficiary’s diagnoses,
  - (6) Detailed information about each of the beneficiary’s prescribed medication(s) to treat the beneficiary’s SED including the name, strength and dosage instructions in layman’s language and any special instructions, including but not limited to, lab work requirements,
  - (7) Information connecting the beneficiary and family with community resources and services including, but not limited to:
    - (a) Address of where follow-up mental health services will be obtained with contact name and phone number.

- (b) Name and address of the school the beneficiary will attend with name and contact information of identified educational staff.
- (c) Other recommended resources, including recreational, rehabilitative, or other special programs including the corresponding contact information.
- (d) Date, time, and location of any scheduled appointments.
- (8) Detailed and specific recommendations in writing about the beneficiary's participation in the MYPAC program including successful techniques in areas of behavior management, mental health treatment and education, and
- (9) The offer of a full array of community-based mental health services for beneficiaries.

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

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

*Rule 6.4: Non-Covered Services*

A. The Division of Medicaid does not cover:

1. Educational interventions of an academic nature performed by the Department of Education,
2. Same service provided on the same date, regardless of the setting(s) in which the service was provided unless service specifically states otherwise.
3. Community-based mental health services when a beneficiary is an inpatient of a Medicaid-covered facility,
4. Time spent on documentation, unless completed during the session and relevant to the treatment goals,
5. Time spent completing a care plan form or prior authorization request online via web portal,
6. Staff travel time,
7. Field trips and routine recreational activities,
8. Beneficiary travel time to and from any service, or



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

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

1. A neuropsychological evaluation when:
  - a) Only administered to rule out attention deficit hyperactivity disorder (ADHD), or
  - b) Previous evaluations did not support the suspicion of cognitive deficits or brain injury.
2. The Division of Medicaid does not cover a developmental evaluation when:
  - a) Referral questions can be adequately answered through behavioral observation and family interviews, or
  - b) A standardized intellectual assessment is appropriate and the beneficiary is three (3) years or older with no severe disabilities.

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

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

*Rule 6.5: Reimbursement*

- A. The Division of Medicaid reimburses expanded rehabilitative services based on a statewide uniform fee schedule.
- B. Providers are reimbursed an all-inclusive rate for beneficiaries receiving Mississippi Youth Programs Around the Clock (MYPAC) services.
  1. Mental health services cannot be billed separately or by another provider for beneficiaries receiving MYPAC services.
  2. MYPAC providers must coordinate with other providers of mental health services to ensure the beneficiary receives and providers are reimbursed for medically necessary services.
  3. Services must be provided for at least thirty (30) minutes in one (1) day to receive the daily rate.
- C. Providers must maintain documentation of each service billed to the Division of Medicaid to substantiate the claim.

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

1. Providers are responsible for coordinating services with the beneficiary and guardian/legal representative to avoid service duplication when the beneficiary is receiving mental health services at more than one (1) location from more than one (1) provider.
2. When duplicate service claims are filed the provider billing the first claim is reimbursed.

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

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

*Rule 6.6: Documentation*

A. The medical record must be in compliance with Miss. Admin. Code Part 200, Rule 1.3 and include the following documentation:

1. Consent for treatment obtained yearly,
2. Date of service,
3. Type of service provided,
4. Time session began and time session ended,
5. Length of time spent delivering the service,
6. Identification of individual(s) receiving or participating in the service,
7. Summary of what transpired in the session,
8. Treatment Plan reviewed and revised as needed every three (3) months or as medically indicated,
9. Evidence that the session relates to the goals and objectives established in the treatment plan,
10. Name, title, and signature of the servicing provider providing the service,
11. Name, title, and signature of the individual who documented the services.
12. All documentation must be legible, easily read and clearly understood.

B. A treatment plan must include, at a minimum:

1. A dimensional approach non-axial diagnosis with separate notations for important psychosocial, contextual factors, and disability,
2. Identification of the beneficiary's and/or family's strengths,
3. Identification of the clinical problems, or areas of need,
4. Treatment goals for each identified problem,
5. Treatment objectives that represent incremental progress towards goals with target dates for achievement,
6. Specific treatment modalities and/or strategies employed to meet each objective,
7. Date of implementation of the treatment plan and signatures of the provider, beneficiary, and parent/guardian.
8. Signatures from the provider and beneficiary to verify the date of review and/or revision to treatment plan.
9. Signatures obtained from each of the appropriate practitioners acknowledging the service that each will provide for the beneficiary.

C. MYPAC Service records must contain the following:

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

- 2) Consent for treatment,
  - 3) Complaints and grievances procedures, and
  - 4) Appeals and right to fair hearing.
2. Assessment documentation must include:
- a) Psychiatric diagnostic evaluation or psychological diagnostic testing evaluation which documents the need for Mississippi Youth Program Around the Clock (MYPAC) level of care (LOC).
    - 1) The original and evaluation and addendum must be stored in the medical record with any addendums.
    - 2) An evaluation must be completed within sixty (60) days prior to admission if no evaluation has been conducted within the last twelve (12) months.
    - 3) An updated addendum must be completed within the fourteen (14) days following MYPAC admission if an evaluation has been conducted within the last twelve (12) months.
  - b) Psychosocial assessment that includes:
    - 1) Medical history,
    - 2) Developmental profile,
    - 3) Behavioral assessment,
    - 4) Assessment of the potential resources of the beneficiary's family,
    - 5) Current educational functioning, and
    - 6) Family and beneficiary strengths and needs
3. Wraparound Service Plan (WSP) documentation must include:
- a) WSP signed and dated by the child and family team and in place within fourteen (14) days of enrollment in MYPAC, and reviewed with wraparound team every thirty (30) days,
  - b) Individualized Crisis Management Program (ICMP) included in the WSP,
  - c) Documentation treatment planning is occurring in the child and family team meetings, and

- d) Treatment Planning is directed by the MYPAC beneficiary and family.
4. Documentation of services provided must include:
- a) Wraparound facilitation progress notes which document:
    - 1) The relationship of services to identified needs of family and beneficiary as stated in the WSP,
    - 2) Detailed narration from face-to-face meetings with the beneficiary and/or family, or collateral contacts, including setting, crisis, barriers and successes, and
    - 3) Date and signature of wraparound facilitator.
  - b) Child and family team meeting notes which document:
    - 1) The purpose and results of services provided that are consistent with the needs outlined in the WSP,
    - 2) Changes to WSP, including dates and reason for changes,
    - 3) Treatment successes,
    - 4) Implementation of the ICMP and outcome, if used,
    - 5) Names and positions or roles of each team member, and
    - 6) Dates and signatures of participating team members.
  - c) Medication management and monitoring documentation must include:
    - 1) Current medication(s) to treat the beneficiary's SED as reflected in the medication profile sheet.
    - 2) Evidence the treating psychiatrist, physician, physician assistant (PA) or psychiatric mental health nurse practitioner (PMHNP) are managing all beneficiary SED medication(s) at least every ninety (90) days, including but not limited to, reviewing, revising, adjusting, discontinuing and monitoring.
    - 3) Feedback on the implementation of the WSP from the psychiatrist employed by the MYPAC provider as Medical Director if the family chooses a different physician to prescribe medication(s) used in the treatment of the beneficiary's SED,

- 4) Administration of medication(s) to treat the beneficiary's SED is accurately performed by the family in accordance with the physician or PMHNP's orders.
  - 5) Informed consent for medication(s) used in the management of the beneficiary's SED is signed by the parent/guardian and beneficiary, if age appropriate, identifying the symptoms the medications target, side effects and evidence of education.
  - 6) Effectiveness of medication(s) to treat the beneficiary's SED.
  - 7) Assistance to family with obtaining, administering and monitoring any medication(s) prescribed for the treatment of the beneficiary's SED.
  - 8) Assessment for side effects of medication(s) to treat beneficiary's SED including physiological testing or other evaluations necessary to monitor for adverse reactions or other health related issues that might arise from taking medication(s) to treat beneficiary's SED.
  - 9) Regular monitoring of medication(s) to treat the beneficiary's SED by the MYPAC provider and reporting any inconsistencies to the treating psychiatrist.
- d) Psychotherapy notes must include:
- 1) Date of session,
  - 2) Time session began and time session ended,
  - 3) Specify if therapy is individual, family or group,
  - 4) Person(s) participating in session,
  - 5) Clinical observations about the beneficiary and/or family, including demeanor, mood, affect, mental alertness, and thought processes,
  - 6) Content of the session,
  - 7) Therapeutic interventions attempted and beneficiary/family's response to the intervention,
  - 8) Beneficiary's response to any significant others who may be present in the session,
  - 9) Outcome of the session,
  - 10) Statement summarizing the beneficiary and/or family's degree of progress toward the treatment goals,

- 11) Signature, credentials and printed name of therapist, and
  - 12) Notes for each session. Monthly summaries are not acceptable in lieu of psychotherapy session notes.
5. Discharge planning documentation must include:
    - a) Discharge planning began the first (1st) day of admission.
    - b) Discharge planning is done with the beneficiary and family through the wraparound process.
    - c) A signed copy of the final discharge plan with signatures of the beneficiary and caregiver/guardian at the time of discharge.
  6. At the time of the beneficiary's discharge from MYPAC services, the discharge/transition plan must be amended to include any of the following, if applicable:
    - a) MYPAC services begin and end date,
    - b) Reason for discharge,
    - c) The name of the person or agency that cares for and has custody of the beneficiary,
    - d) The physical location/address where the beneficiary resides,
    - e) A list of the beneficiary's diagnoses,
    - f) Detailed information about the beneficiary's prescribed medication(s) to treat the beneficiary's SED including the names, strengths and dosage instructions and side effects in layman's terms and any special instructions, including but not limited to, lab work requirements,
  7. Discharge planning documentation must include:
    - a) Discharge planning began the first (1st) day of admission.
    - b) Discharge planning is done with the beneficiary and family through the wraparound process.
    - c) A signed copy of the final discharge plan with signatures of the MYPAC beneficiary and caregiver/guardian at the time of discharge.
    - d) A thirty (30) day prescription for each of the beneficiary's medications.

- e) Signed consent from the beneficiary and family to provide copies of the final discharge plan to the providers of follow-up mental health, education and other services to be provided after discharge.

D. Documentation of services must comply with the Department of Mental Health's Record Guide and any supplemental instructions provided by DMH in effect at the time the service is provided.

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

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