Title 23: Division of Medicaid

Part 203: Physician Services

Part 203 Chapter 9: Psychiatric Services

Rule 9.1: Provider Qualifications

Psychiatric services described in this chapter must be provided by a licensed physician (medical doctor or doctor of osteopathy) who is board-certified in psychiatry or by a licensed Psychiatric Mental Health Nurse Practitioner (PMHNP). Rules included in this chapter do not apply to psychologists.

Source: Miss. Code Ann. § 43-13-121

Rule 9.2: General Requirements

A. All services must be personally and directly provided by the psychiatrist or PMHNP who requests reimbursement for the service.

B. Services must be based on beneficiary need and not the convenience of the beneficiary, the beneficiary's family or the provider.

C. A provider may bill only for the actual time spent in service delivery.

Source: Miss. Code Ann. § 43-13-121

Rule 9.3: Covered Services

The following psychiatric services are eligible for reimbursement by Medicaid only when they have been personally and directly provided by a licensed physician (medical doctor or doctor of osteopathy) who is board-certified in psychiatry or by a licensed Psychiatric Mental Health Nurse Practitioner (PMHNP):

A. Evaluative Services which include a psychiatric interview ok an interactive psychiatric interview.

B. Therapeutic Services which include individual, family, and group psychotherapy.

C. Other psychiatric services/procedures including

    1. Medication evaluation, and

    2. Electroconvulsive therapy.

Source: Miss. Code Ann. § 43-13-121

Rule 9.4: Non-Covered Services

A. Services are not eligible for reimbursement unless they are personally and directly provided by the servicing provider.

B. Educational interventions of an academic nature are not eligible for Medicaid reimbursement.

C. Medicaid will not reimburse more than once for the same service provided to any beneficiary on any given date, regardless of the setting(s) in which the service was provided. It is the provider's responsibility to coordinate services with the beneficiary and/or his/her family member to insure that services are not duplicated.

Source: Miss. Code Ann. § 43-13-121

Rule 9.5: Service Limits

A. The Division of Medicaid defines service limits as the maximum quantity of services per beneficiary that are eligible for reimbursement by the Division of Medicaid within a given time frame, either daily or yearly.

B. The following daily service limits apply to beneficiaries, regardless of the setting, hospital/residential or community-based, in which the services are provided:

1. Individual and Family Therapy - No more than one (1) service in any of the categories of individual psychotherapy or family psychotherapy is eligible for reimbursement by Medicaid on any given day.

2. Group Therapy

a) Generally, one (1) service of group therapy can be billed per day.

b) Two (2) services in group psychotherapy may be eligible for reimbursement on any given day when the following criteria are met:

1) Two (2) distinct sessions, each having mutually exclusive goals and objectives, are provided, and

2) Two (2) sessions per day are medically necessary, and

3) Two (2) sessions per day are appropriate and in accordance with the standards of medical practice, and

4) Documentation in the clinical record substantiates that the above criteria were met.

C. The following yearly service limits apply to adult beneficiaries aged twenty-one (21) years and older:

1. Psychiatric Outpatient Services - Beneficiaries are limited to twelve (12) covered psychiatric services/procedures per fiscal year (July 1-June 30). This psychiatric service benefit is available separate from the twelve (12) covered outpatient physician visits allowed for each adult Medicaid beneficiary.

2. Hospital Inpatient Services

   a) Inpatient hospital psychiatric services are reimbursed under the APR-DRG methodology and are available only if the services are determined to be medically necessary by the Utilization Management/Quality Improvement Organization (UM/QIO). Day outlier payments may be made for mental health long lengths of stay for exceptionally expensive cases.

   b) Prior authorization is required upon admission and for lengths of stay greater than nineteen (19) days.

   c) One (1) covered psychiatric service/procedure is eligible for reimbursement per beneficiary per certified day in a general hospital or acute freestanding psychiatric facility.

Source: Miss. Code Ann. § 43-13-121

History: 10/01/2012

Rule 9.6: Documentation

A. Physicians are required to maintain auditable records that will verify any or all services provided and billed under the Medicaid program.

   1. Records must, be made available to representatives of the Division of Medicaid or Office of the Attorney General in substantiation of claims.

   2. Records must be maintained for a minimum of five (5) years in order to comply with all state and federal regulations and laws. Refer to Maintenance of Records Part 200, Ch.1, Rule 1.3.

B. It is expected that the initial psychiatric service provided to any beneficiary must be of an evaluative nature. Documentation of the evaluation must be in the case record and must include, at a minimum:

   1. Dates, including beginning and ending session times, and the amount of time spent,

   2. Chief complaint,

3. Referral source,

4. History of present illness,

5. Past psychiatric history,

6. Past medical history,

7. List of the beneficiary's current medications including prescription, non-prescription and over-the-counter,

8. Social and family history,

9. Comprehensive mental health status examination,

10. Treatment plan formulation/prognosis,

11. Assessment of the patient's ability to adhere to the treatment plan,

12. A multi-axial diagnosis,

13. Identification of the clinical problems that are to be the focus of treatment,

14. Treatment modalities and/or strategies that will be employed or are recommended to address each problem. If medications are prescribed, documentation must include the name of the drug, strength and dosage. The method of administration must be included for injectable medications. Medication prescriptions must be identified as issued in writing, electronically, or by telephone, and

15. The signature of the person who provided and documented the service. Any note that is "signed" by computer must be initialed by hand.

C. A treatment plan must be developed and implemented for each beneficiary no later than the date of the third (3rd) therapy session.

1. The treatment plan must include, at a minimum:

   a) A multi-axial diagnosis,

   b) Identification of the beneficiaries' and/or family's strengths,

   c) Identification of the clinical problems, or areas of need, that is to be the focus of treatment,

   d) Treatment goals for each identified problem,

e) Treatment objectives that represent incremental progress towards goals, coupled with target dates for their achievement,

f) Specific treatment modalities and/or strategies that will be employed to reach each objective, and

g) Date of implementation and signatures of the provider and the beneficiary or parent/legal guardian.

2. Treatment plans must be kept in the case record and must be reviewed and revised as needed, or at least every three (3) months. Each review must be verified by the dated signatures of the provider and beneficiary/parent/legal guardian. The physician, nurse practitioner, psychologist, and clinical social worker must sign the treatment plan for the services each will provide to the beneficiary.

D. A clinical note for each therapeutic service provided must be in the case record and must:

1. Include the date of service, type of service provided, the length of time spent delivering the service, who received or participated in it, as well as a brief summary of what transpired. If medications are prescribed, documentation must include the name of the drug, strength and dosage. The method of administration must be included for injectable medications. Medication prescriptions must be identified as issued in writing, electronically, or by telephone.

2. Indicate whether Evaluation and Management services are provided.

3. Relate to the problems identified in clinical record.

4. Identify whether the service occurs in an inpatient or outpatient setting.

5. Be authenticated by the signature of the person who provided and documented the service. Any note that is "signed" by computer must be initialed by hand.

Source: Miss. Code Ann. § 43-13-121

Rule 9.7: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

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   a) Inpatient hospital psychiatric services are reimbursed under the APR-DRG methodology and are available only if the services are determined to be ~~Inpatient Hospital is certified as~~ medically necessary by the Utilization Management/Quality Improvement Organization (UM/QIO). Day outlier payments may be made for mental health long lengths of stay for exceptionally expensive cases.

   b) ~~A maximum of thirty (30) days of hospital stay are eligible for reimbursement by Medicaid per adult beneficiary per fiscal year, regardless of the nature of the problem (physical or psychiatric) for which the beneficiary is hospitalized. This limitation applies to inpatient crossover claims.~~ Prior authorization is required upon admission and for lengths of stay greater than nineteen (19) days.

   c) One (1) covered psychiatric service/procedure is eligible for reimbursement per beneficiary per certified day in a general hospital or acute freestanding psychiatric facility.

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