Administrative Code

Title 23: Medicaid
Part 222
Maternity Services

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Part 222 Chapter 1: General

Rule 1.1: Maternity Services

A. The Division of Medicaid covers maternity services which include:

1. Antepartum services defined by the Division of Medicaid as the care of a pregnant woman during the time in the maternity cycle that begins with conception and ends with labor.

2. Delivery services defined by the Division of Medicaid as the care involved in labor and delivery.

3. Postpartum services defined by the Division of Medicaid as the care of the mother inclusive of both hospital and office visits following delivery for twelve (12) months including any remaining days in the month in which the twelfth (12^{th}) month occurs.

B. The Division of Medicaid covers inductions of labor or cesarean sections prior to one (1) week before the treating physician's expected date of delivery when medically necessary due to one (1) of the following medical and/or obstetric conditions including, but not limited to:

1. Non-reassuring fetal status or fetal compromise,

2. Fetal demise in prior pregnancy,

3. Fetal malformation,

4. Intrauterine Growth Restriction (IUGR),

5. Preeclampsia,

6. Eclampsia,

7. Isoimmunization,

8. Placenta previa, accreta, or abruption,

9. Thrombophilia or an occurrence of maternal coagulation defects,

10. Complicated chronic or gestational hypertension,

11. Chorioamnionitis,

12. Premature rupture of membranes,
13. Oligohydramnios,
14. Polyhydramnios,
15. Multiple gestations,
16. Poorly controlled diabetes mellitus (pregestational or gestational),
17. HIV infection,
18. Pulmonary disease,
19. Renal disease,
20. Liver disease,
21. Malignancy,
22. Cardiovascular diseases,
23. Classical or vertical uterine incision from prior cesarean delivery, or
24. Prior myomectomy.

C. The Division of Medicaid does not cover non-medically necessary early elective deliveries, prior to the expected due date including, but not limited to, the following:

1. Maternal request,
2. Convenience of the beneficiary or family,
3. Maternal exhaustion or discomforts,
4. Availability of effective pain management,
5. Provider convenience,
6. Facility scheduling,
7. Suspected macrosomia with documented pulmonary maturity with no other medical indication,
8. Well-controlled diabetes,

9. History of rapid deliveries,

10. Long distance between beneficiary and treating facility, or

11. Adoption.

D. Medical records will be subject to retrospective review. Reimbursement for hospital and professional services related to the delivery will be recouped if determined not to have met criteria for coverage.

E. Antepartum and postpartum office visits do not apply to the physician services limit.

F. A period of presumptive eligibility is provided to pregnant women according to the following:

1. Presumptive Eligibility for Pregnant Women (PEPW) covers ambulatory prenatal care for pregnant women that are determined presumptively eligible by a qualified provider on the basis of preliminary information.

2. Ambulatory prenatal care includes medically necessary pregnancy-related services rendered in a clinic or outpatient setting, outpatient labs and exams, and pregnancy related prescription drugs prescribed by a licensed Medicaid provider.

a) Birthing expenses and hospital services are not covered during a period of presumptive eligibility.

b) All State Plan limits apply to services provided during a period of presumptive eligibility.

3. In order to enroll as a qualified provider for PEPW determinations, providers must:

a) Satisfy the requirements set forth in Miss. Admin. Code Title 23, Part 200, Chapter 4,

b) Submit the Application for PEPW Qualified Provider and an executed Memorandum of Understanding (MOU), and

c) Be enrolled with the Mississippi Division of Medicaid as one of the following provider types:
1) Federally Qualified Health Center (FQHC),

2) Mississippi Department of Health (MSDH) County Health Department,

3) Rural Health Clinic (RHC),

4) Obstetrician, or

5) Primary Practice Clinic.

d) Providers may be disqualified from making PEPW determinations for failure to meet the following timeliness and accuracy performance standards:

1) Ninety-five percent (95%) of beneficiaries determined presumptively eligible by the provider must submit Medicaid applications prior to the end of the presumptive eligibility period.

2) Ninety-five percent (95%) of beneficiaries that submit a timely Medicaid application must be determined eligible for Medicaid.

4. The presumptive eligibility period begins on the date the determination is made and ends at the earlier of the:

a) The date of approval or denial of the filed Medicaid application, if an application for Medicaid has been filed by the last day on the month following the month in which the presumptive eligibility determination is made, or

b) The last day of the month following the month in which the determination of presumptive eligibility was made, if an application for Medicaid was not filed.

5. The qualified provider must notify the Division of Medicaid within five (5) business days of the date the determination is made.

6. There may be no more than one (1) presumptive eligibility period per pregnancy.

Source: Miss. Code Ann. §§ 43-13-115(8), 43-13-117, 43-13-121.

History: Revised to correspond with MS SPA 24-0010 (eff. 07/01/2024) eff. 01/01/2026. Revised to correspond with MS SPA 23-0015 (eff. 04/01/2023) eff. 04/01/2024. Revised eff. 01/02/2015.

Rule 1.2: [Reserved]

Rule 1.3: Maternal Fetal Ultrasound

A. For a fetal biophysical profile, the physician may bill one (1) unit for each fetus being evaluated in cases of multiple gestations.

B. For an ultrasound during hospitalization, Medicaid reimburses the physician submitting a claim for a visit and a review of an ultrasound on the same date of service for the visit only. A physician's interpretation of the results of an ultrasound will be reimbursed as a separate service when prepared with a separate distinctly identifiable signed written report using the appropriate procedure code with the appropriate modifier which indicates professional

component only.

C. Medicaid does not cover routine sonography during pregnancy.

D. Medicaid covers medically necessary ultrasounds when all of the following criteria are met:

1. The ultrasound is consistent with the beneficiary's signs, symptoms, and/or condition,

2. Diagnosis cannot be made through clinical evaluation of the beneficiary's signs and symptoms, and

3. The results of the ultrasound can reasonably be expected to influence the beneficiary's treatment plan.

E. For Medicaid reimbursement for any type of obstetrical ultrasound, documentation in the beneficiary's record must justify the medical necessity. This documentation includes, but is not limited to, at least one (1) of the following:

1. Fetal measurements, as applicable to gestational age, such as crown-rump length, biparietal diameter (BPD), occipitofrontal diameter/head circumference (OFD or HC), abdominal circumference (AC), or femur length (FL),

2. Fetal position,

3. Placental location,

4. Amniotic fluid assessment or measurement,

5. Suspected or known fetal anomalies or conditions,

6. Fetal measurements relative to determination of suspected or known intrauterine growth retardation (IUGR), or

7. Presence of multiple gestations.

F. Documentation must reflect the type of obstetrical ultrasound actually performed, limited or complete.

G. The biophysical profile combines ultrasound with a non-stress test to check fetal well-being. The five (5) fetal parameters checked are as follows:

1. Reactive non-stress test,

2. Fetal breathing movement,

3. Fetal body movement,

4. Fetal muscle tone, and

5. Amniotic fluid volume.

H. Documentation must include a report on each of the five (5) parameters listed in Part 222, Chapter 1 Rule 1.3.G.

I. Providers must maintain proper and complete documentation to verify services provided.

1. The provider has full responsibility for maintaining documentation to justify the services provided.

2. Records must be documented and maintained in accordance with requirements set forth in Part 200, Chapter 1, Rule 1.3.

Source: Miss. Code Ann. § 43-13-121

Rule 1.4: Maternity Epidurals

A. Medicaid covers a maternity epidural for all pregnant Medicaid beneficiaries. Medicaid considers maternity epidurals as a medically necessary service for treatment of labor pain and does not consider it an elective procedure.

B. A physician who is participating in the Medicaid program must take all reasonable measures to ensure that maternity patients are instructed and offered an epidural as an available and covered service under Medicaid as part of the patient's prenatal counseling. The patient's options for pain relief medication during childbirth must be explained to her.

C. Anesthesiologists/CRNAs cannot refuse to provide a maternity epidural to a Medicaid beneficiary except when medically contraindicated.

1. An anesthesiologist/CRNA who is participating in the Medicaid program must make available and offer maternity epidural services to pregnant Medicaid beneficiaries and cannot require a pregnant Medicaid beneficiary to pay for an epidural.

2. He/she must accept the Medicaid payment as payment in full and cannot require a co-payment for his/her services. Under federal Medicaid law, deductions, cost sharing, or similar charges are not permitted for Medicaid services furnished to pregnant women. Thus, a participating provider's demand for these additional payments would be in violation of the law.

3. The decision to have an epidural is to be decided between the beneficiary and her anesthesiologist/CRNA in consultation with the obstetrician. No means of coercion, dissuasion, or refusal by an anesthesiologist/CRNA to provide an epidural to a beneficiary in labor shall be utilized in determining this decision.

D. A hospital that accepts a pregnant Medicaid beneficiary for treatment accepts the responsibility for making sure that the beneficiary has access to an epidural.

1. If an anesthesiologist does not accept a Medicaid patient for treatment, the hospital has the responsibility of assuring the delivery of this service.

2. A pregnant beneficiary is entitled to receive the service from a provider who has accepted her as a patient without the imposition of deductibles, cost sharing, or similar charges.

Source: Miss. Code Ann. § 43-13-121

Rule 1.5: [Reserved]

History: Removed eff. 01/02/2015.

Rule 1.6: Reimbursement for Delivery and Tubal Ligation

A delivery, cesarean section or vaginal, and a tubal ligation performed at the same setting will be reimbursed at one hundred percent (100%) of the fee schedule for each procedure.

Source: Miss. Code Ann. § 43-13-121

Rule 1.7: Sterilization

Medicaid reimburses covered sterilization procedures when the criteria for covered sterilization are satisfied in accordance with Part 202, Chapter 1, Rule 1.8.

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

Rule 1.8: Terbutaline Therapy

Terbutaline pump therapy with uterine activity monitoring for beneficiaries who are at risk for preterm labor is not covered by Medicaid.

Source: Miss. Code Ann. § 43-13-121

Rule 1.9: [Reserved]

Rule 1.10: 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

Rule 1.11: Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services

A. The Division of Medicaid defines Screening, Brief Intervention, and Referral to Treatment (SBIRT) as an early intervention approach that targets pregnant women with nondependent substance use to provide effective strategies for intervention prior to the need for more extensive or specialized treatment.

B. SBIRT services must include:

   1. Screening of a pregnant woman for risky substance use behaviors using evidence based standardized assessments or validated screening tools,

   2. Brief intervention of a pregnant woman showing risky substance use behaviors in a short conversation, providing feedback and advice, and

   3. Referral to treatment for brief therapy or additional treatment to a pregnant woman whose assessments or screenings indicate a need for additional services.

C. The Division of Medicaid covers one (1) SBIRT service per pregnancy when performed by one (1) of the following licensed practioners:

   1. Physician,

   2. Nurse Practioner,

   3. Certified Nurse Midwife,

   4. Physician Assistant,

   5. Licensed Clinical Social Worker,

   6. Licensed Professional Counselor, or

   7. Clinical Psychologist.

D. SBIRT services provided through a Community Mental Health Center or Private Mental Health Center must be performed by one (1) of the licensed practitioners listed in Miss. Admin. Code Part 222, Rule 1.11.

E. The Division of Medicaid reimburses for SBIRT services according to Healthcare Common Procedure Coding System (HCPCS) guidelines and in accordance with applicable provider reimbursement methodologies.

   1. SBIRT services provided by Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), and the Mississippi State Department of Health (MSDH) providers,

are covered in the encounter rate for core services. An encounter cannot be paid solely for SBIRT services.

2. SBIRT services are not covered in an inpatient hospital setting.

F. The Division of Medicaid covers all medically necessary services for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) eligible beneficiaries in accordance with Miss. Admin. Code Part 223 without regard to service limitations and with prior authorization.

G. Providers of SBIRT services must document and maintain auditable records that meet the requirements set in Part 200, Chapter 1. Rule 1.3 including the following:

1. A copy of the evidence based standardized assessment screening tool with scoring,

2. Brief description of the intervention, and

3. Referral information.

Source: 42 C.F.R. §§ 440.210, 440.250; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: New rule to correspond to SPA 17-0003 (eff. 07/01/2017), eff. 11/01/2017.

Rule 1.12: Tobacco Cessation Counseling Services

A. The Division of Medicaid covers one (1) face-to-face counseling session per quit attempt with mandatory referral to the Mississippi (MS) Tobacco Quit Line for pregnant women who use tobacco.

B. Face-to-Face sessions must be provided by:

1. Or under supervision of a physician,

2. Any other health professional who is legally authorized to furnish such services under State Law and who is authorized to provide Medicaid coverable services other than tobacco cessation services, or

3. Any other health professional legally authorized to provide tobacco cessation services under State Law and who is specifically designated by the Secretary in regulations.

C. The Division of Medicaid covers tobacco cessation counseling services in the encounter rate for a core service for Rural Health Clinics (RHC), Federally Qualified Health Centers (FQHC), and the Mississippi State Department of Health (MSDH) providers.

D. The Division of Medicaid does not reimburse for an encounter if the only service provided is tobacco cessation counseling services.

E. The Division of Medicaid reimburses for services made from a statewide uniform fee schedule and paid at the lesser of the usual and customary charge on the physician's fee schedule.

Source: 42 U.S.C. § 1396d; Miss. Code Ann. § 43-13-121; SPA 2013-002.

History: New Rule to correspond with SPA 2013-002 (effective 03/01/14), eff. 03/01/2019.

Part 222 Chapter 2: Perinatal High Risk Management and Infant Services

Rule 2.1: Provider Participation

A. The provider, agency, or entity of Targeted Case Management (TCM) services for high-risk women who are pregnant and up to sixty (60) days postpartum or high-risk infants through one (1) year of age must comply with the requirements to enroll as a Mississippi Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Provider and meet the following requirements:

1. Have a minimum of two (2) years' experience providing comprehensive case management services to the target population,

2. Have an established system to coordinate services for Medicaid beneficiaries,

3. Have established referral systems, linkages, and referral ability with essential social and health services agencies, and

4. Employ Registered Nurses with the following qualifications as case managers:

    a) Be licensed by the Mississippi Board of Nursing and in good standing,

    b) Have one (1) year documented experience working with the target population,

    c) Have experience, skills, and/or training in crisis intervention,

    d) Have effective communication skills,

    e) Have access to multi-disciplinary staff, when needed, and

    f) Possess knowledge of resources for the service community.

Source: Miss. Code Ann. §§ 43-13-121, 43-13-117(19)(a)

History: Revised eff. 07/01/2024.

Rule 2.2: Covered Services

A. A medical risk screen must be conducted to determine the need to refer an individual for Targeted Case Management (TCM) services. Referrals for TCM services must be initiated during the pregnancy for the woman, or birth through one (1) year of age for the infant. The medical risk screen must:

1. Be completed by a physician, physician assistant, a nurse practitioner, or certified nurse-midwife,

2. Only be conducted once per pregnancy unless the beneficiary changes providers and the new provider is unable to obtain the beneficiary's medical records, and

3. Be completed up to two (2) times for infants, if risk factors are present.

B. Targeted Case Management is a collaborative process of assessment, care planning, care coordination, and evaluation of services to meet the identified needs of eligible women who are pregnant and up to sixty (60) days postpartum or infants from birth through (1) year of age. TCM activities include:

1. An initial comprehensive assessment that is beyond risk screening must be conducted to determine the specific needs of the participant and identify which, if any, referrals for extended or other services are needed. The initial comprehensive assessment must, at a minimum:

   a) Be performed by the RN case manager,

   b) Be completed within fifteen (15) calendar days after the referral is received for TCM, and

   c) Be maintained in the participant's case record.

2. A Plan of Care (POC) must be developed and periodically updated which, at a minimum:

   a) Reflects the specific needs identified through applicable assessments,

   b) Establishes specific goals (long and short-term),

   c) Includes interventions to address the participant's goals and meet the identified needs,

   d) Must be action oriented with identifiable outcomes that are measurable and achievable within a manageable time frame,

   e) Must be updated timely to reflect changes in the participant's needs or status,

   f) Identifies each interdisciplinary team member's responsibilities in addressing identified needs, and

g) Provides a personalized discharge plan that, at a minimum, identifies all goals or needs that extend beyond case closure. Processes must be in place to coordinate appropriate linkages and services prior to case closure. Discharge planning must be documented in the case file.

3. Care Coordination includes regular communication, information-sharing, and collaboration between case management and others serving the participant, within a single agency or among several community-based agencies. All care coordination activities must be recorded in the case file and must, at a minimum include:

   a) Regular communication with the participant, participant's family or authorized representative, provider(s), and the interdisciplinary team,

   b) Coordinating access to services and benefits, reducing barriers, and establishing linkages with other services providers,

   c) Referrals and related activities including, but not limited to, scheduling appointments to help the participant obtain needed services and linking the participant with medical, social, educational, or other program(s) or resource(s) that are capable of providing needed services to address identified needs and achieve goals specified in the POC,

   d) Revising the POC to reflect the changes in the needs or status of the participant,

   e) Processes for participant transfer to a new TCM provider, if chosen, and

   f) Making appropriate referrals as needed and upon case closure to ensure continuation of care.

4. Monitoring and follow-up activities include activities and contacts that are necessary to ensure the POC is implemented and adequately addresses the participant's needs. Activities may be with the participant, the participant's personal or authorized representative, or the participant's service provider and must be conducted at least monthly and more often as necessary. Monitoring and follow-up activities include, but are not limited to:

   a) Monthly face-to-face contact with the participant,

   b) Monthly case conference with the interdisciplinary team,

   c) Initial contact with the participant's primary care provider(s) upon enrollment into the program and continued communication with the primary care provider(s) if the participant's condition or status changes,

   d) Routine review and follow-up of case notes from all service providers, and

e) Review and revision of the POC routinely and as needed.

C. Extended services for eligible participants who are pregnant and up to sixty (60) days postpartum or infants from birth through one (1) year of age are based upon the specific needs identified on the initial comprehensive assessment.

1. Appropriate referral(s) for extended services must be initiated by the case manager.

2. Any extended service(s) being provided must be included in the POC and evaluated by the case manager at least monthly. Extended services include:

a) Initial nursing assessment and evaluation performed by a registered nurse (RN) within ten (10) business days from referral,

b) Nursing services performed by an RN which must include health education,

c) Home visit for postpartum assessment and follow-up performed by an RN,

d) Nutritional assessment and counseling performed by a registered dietician or licensed nutritionist within ten (10) business days from referral,

e) Nutritional counseling and dietician visit performed by a registered dietician or licensed nutritionist,

f) Mental health assessment performed by a non-physician practitioner within ten (10) business days from referral, and

g) Behavioral health prevention education services performed by a mental health professional.

Source: Miss. Code Ann. §§ 43-13-121, 43-13-117(19)(a); 42 CFR § 440.169.

History: Revised eff. 07/01/2024.

Rule 2.3: Documentation Requirements

A. To qualify for reimbursement, a case file with adequate documentation must be maintained for each participant receiving Targeted Case Management (TCM) through the Perinatal High-Risk Management/Infant Services System (PHRM/ISS) program. Each TCM case file must, at a minimum, contain:

1. The name of the individual, as well as other personal information including, but not limited to:

a) Date of birth and Medicaid ID number,

b) Expected date of delivery,

c) Date when prenatal care began,

d) Name of primary provider,

e) Delivery date,

f) Delivery method,

g) Birth control plan chosen by participant,

h) Date(s) of postpartum visit(s) with medical provider,

i) Date of postpartum home visit with Extended Service RN,

j) Birth weight, and

k) Dates of EPSDT well-child visits

l) Release of information consent;

2. The dates and other information regarding case management services including:

a) Medical risk screening form including, but not limited to:

1) Date screening was performed,

2) Name of person/provider completing medical risk screen, and

3) Specific risk factors identified

b) Referral date and referral source,

b) Enrollment date,

c) Assessment dates;

3. The name of the provider agency (if relevant) and the person providing the case management service.

a) Participant transfer to new TCM provider including, but not limited to:

1) Reason for transfer to new TCM provider,

2) Transfer consent form signed and dated by participant, and

3) Transfer notes;

4. The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved.

   a) Screening/assessment results,

   b) Long and short-term goals with time frame for completion,

   c) Planned interventions,

   d) Outcome of interventions,

   e) Dates and reasons for review and/or revision, and

   f) Discharge plans and case closure documentation including, but not limited to:

      (1) Reason for closure,

      (2) Services provided and outcomes, including any unmet goals and/or ongoing needs,

      (3) Referrals to providers and other resources to address unmet goals and ongoing needs, and

      (4) Notification to participant and primary care provider(s) regarding case closure and any post case closure referrals that have been made;

5. Whether the individual has declined services in the care plan and the individual's signature declining the service.

6. The need for, and occurrences of, coordination with other case managers, including:

   a) Documentation of referrals:

      (1) Date of referral,

      (2) Name of provider/entity to whom the referral was made,

      (3) Reason for referral, and

      (4) Outcome of referral(s);

   b) Case Conference including, but not limited to:

(1) Date of case conference,

(2) Case conference attendees, and

(3) Case conference notes including interdisciplinary team recommendations/plans and any revisions to the POC;

7. A timeline for obtaining needed services.

8. A timeline for reevaluation of the plan.

Source: Miss. Code Ann. §§ 43-13-121, 43-13-117, 43-13-118, 43-13-129; 42 CFR § 441.18.

History: Revised eff. 07/01/2024.

Rule 2.4: Freedom of Choice

A. Medicaid beneficiaries have the right to freedom of choice of providers for Medicaid covered services. Refer to Part 200, Chapter 3, Rule 3.6.

B. Perinatal High-Risk Management/Infant Services System (PHRM/ISS) Targeted Case Management (TCM) services will not restrict an individual's free choice of providers. An eligible beneficiary may choose to receive extended or enhanced services through any PHRM/ISS provider.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 441.18; Social Security Act 1902(a)(23)

History: Revised eff. 07/01/2024.

Rule 2.5: Reimbursement

A. The provider must bill the appropriate HCPCs code and modifier HD for maternity and infant services to be reimbursed under the PHRM/ISS program.

B. Payments under the plan must not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

C. Only medically necessary services are covered under the Medicaid program.

Source: Miss. Code Ann. §§ 43-13-121, 43-13-117; 42 CFR § 441.18.

History: Revised eff. 07/01/2024.

Rule 2.6: 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.

History: Revised eff. 07/01/2024.