



## Administrative Code

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Title 23: Medicaid  
Part 222  
Maternity Services

## Table of Contents

Title 23: Division of Medicaid.....	1
Part 222: Maternity Services.....	1
Part 222 Chapter 1: General.....	1
Rule 1.1: Maternity Services.....	1
Rule 1.2: Multiple Birth Deliveries.....	1
Rule 1.3: Maternal Fetal Ultrasound.....	2
Rule 1.4: Maternity Epidurals.....	3
Rule 1.5: Billing for Maternity Services.....	4
Rule 1.6: Reimbursement for Delivery and Tubal Ligation.....	5
Rule 1.7: Sterilization.....	5
Rule 1.8: Terbutaline Therapy.....	5
Rule 1.9: 17 Alpha-Hydroxyprogesterone.....	5
Rule 1.10: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).....	5
Part 222 Chapter 2: Perinatal High Risk Management and Infant Services.....	6
Rule 2.1: Provider Participation.....	6
Rule 2.2: Freedom of Choice.....	7
Rule 2.3: High Risk Pregnant Women.....	7
Rule 2.4: High Risk Infants.....	8
Rule 2.5: Plan of Care.....	9
Rule 2.6: Medical Record Documentation Requirements.....	10
Rule 2.7: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).....	11

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

### **Part 222: Maternity Services**

#### **Part 222 Chapter 1: General**

##### *Rule 1.1: Maternity Services*

- A. Medicaid covers maternity services which include all antepartum care, the delivery, and postpartum services.
1. Medicaid defines antepartum services as the care of a pregnant woman during the time in the maternity cycle that begins with conception and ends with labor.
  2. Medicaid defines delivery services as the care involved in the actual birth and continues for two (2) months following the month of the birth of the newborn.
  3. Medicaid defines postpartum services as services inclusive of both hospital and office visits following vaginal and cesarean section deliveries. Eligible pregnant women continue to be eligible for postpartum medical assistance for a sixty (60) day period beginning on the last day of her pregnancy and for any remaining days in the month in which the sixtieth (60<sup>th</sup>) day falls.
- B. Reporting is required for hospital admissions for obstetrical deliveries.

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

##### *Rule 1.2: Multiple Birth Deliveries*

- A. Medicaid covers multiple birth deliveries, same delivery setting, when two (2) or more infants from one (1) pregnancy are delivered vaginally in the same delivery setting. One (1) vaginal delivery fee at one hundred percent (100%) of the Medicaid allowable rate, and one (1) additional vaginal delivery fee will be reimbursed at fifty percent (50%) of the Medicaid allowable rate.
- B. Medicaid covers multiple birth deliveries, same delivery setting, when two (2) or more infants from one (1) pregnancy are delivered by cesarean section in the same operative setting. One (1) cesarean section delivery fee at one hundred percent (100%) of the Medicaid allowable rate, and one (1) additional cesarean section delivery fee will be reimbursed at fifty percent (50%) of the Medicaid allowable rate.
- C. Medicaid covers multiple birth deliveries, same delivery setting, when at least one (1) infant of a multiple pregnancy is delivered vaginally followed by one (1) or more infants delivered by cesarean section. The cesarean section fee at one hundred percent (100%) of the Medicaid allowable rate, and one (1) vaginal delivery fee will be reimbursed at fifty percent (50%) of the Medicaid allowable rate.

D. Medicaid covers multiple birth deliveries, separate delivery settings, with delayed interval deliveries each at one hundred percent (100%) of the Medicaid allowable rate for the appropriate procedure. In the case of multiple births of three (3) or more infants where one (1) infant is delivered during one setting followed by two (2) or more infants delivered later in a separate setting, Medicaid covers the second (2<sup>nd</sup>) delivery of the multiple birth in accordance with the same setting policy outlined in Rule 1.2.A of this Chapter.

Source: Miss. Code Ann. § 43-13-121

*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: Billing for Maternity Services*

Medicaid reimburses delivering physicians for maternity services provided to eligible Medicaid beneficiaries. Providers must utilize evaluation and management procedure codes to bill antepartum visits.

- A. Providers must utilize appropriate procedure codes to be reimbursed for deliveries, postpartum care, postpartum hospital visits and office visits. Postpartum care is inclusive of both hospital and office visits following vaginal and cesarean section deliveries.
- B. Physicians may bill the appropriate evaluation and management procedure code for reimbursement when the postpartum office visit is the only service provided by the physician.

C. The applicable modifier which identifies “obstetrical treatment/services, prenatal and postpartum” must be reported with each procedure code for antepartum visits and deliveries and postpartum care.

1. Medicaid utilizes this modifier to track data and to bypass the physician visit limitation of twelve (12) visits per fiscal year.
2. Antepartum office visits are not subject to this limitation.

Source: Miss. Code Ann. § 43-13-121

*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: 17 Alpha-Hydroxyprogesterone*

Medicaid covers the injection of 17 Alpha-Hydroxyprogesteron (17-P) in accordance with Part 203, Chapter 2, Rule 2.6.

Source: Miss. Code Ann. § 43-13-121

*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

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

### *Rule 2.1: Provider Participation*

- A. The Division of Medicaid covers the multidisciplinary case management program known as the Perinatal High Risk Management/Infant Services System (PHRM/ISS) program, administered by the State Department of Health, for certain Medicaid eligible pregnant/postpartum women and infants.
- B. Any physician or clinic licensed to practice in the State of Mississippi or other approved practitioner actively enrolled as a Mississippi Medicaid provider may provide PHRM/ISS services as a High Risk Case Management Agency.
- C. Providers must meet all the following qualifications:
  - 1. Meet applicable state and federal laws governing the participation of providers in the Medicaid program.
  - 2. Meet the criteria established by the Division of Medicaid as a provider of high risk case management agency services.
  - 3. Be enrolled by the Division of Medicaid as an EPSDT provider to provide high risk infant services
  - 4. Must have qualified case managers who meet the qualifications applicable to their specific disciplines.
    - a) Medical Discipline: Case manager must be one (1) of the following:
      - 1) Physician licensed in Mississippi.
      - 2) Physician assistant licensed in Mississippi.
      - 3) Nurse practitioner licensed in Mississippi.
      - 4) Nurse-midwife certified in Mississippi.
      - 5) Registered nurse licensed in Mississippi with a minimum of one (1) year of experience in community nursing.
    - b) Psychosocial Discipline: Social worker with a minimum of one (1) year of experience in health and/or human services, and one (1) of the following:
      - 1) Masters in Social Work (MSW) social worker licensed in Mississippi.

- 2) Bachelor in Social Work (BSW) social worker licensed in Mississippi in consultation with an MSW.
  - 3) Other Mississippi licensed social worker supervised by an MSW.
- c) Nutritional Discipline: Nutritionist licensed in Mississippi or a registered dietitian, with a minimum of one (1) year of experience in providing nutritional services to pregnant women and infants. The nutritionist/dietitian may only serve as a case manager for enrollees for whom nutritional problems are their primary risk.

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

*Rule 2.2: 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. The PHRM/ISS case management 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; Social Security Act 1902(a)(23)

*Rule 2.3: High Risk Pregnant Women*

- A. A maternity medical risk screening is required to determine if a beneficiary is eligible for PHRM services.
  1. A beneficiary qualifies for PHRM services if one (1) or more positive risk factors are identified.
  2. The medical risk screening must be completed by a physician, physician assistant, a nurse practitioner, or a certified nurse-midwife.
  3. Only one (1) medical risk screening is covered during each pregnancy unless the beneficiary changes providers and the new provider is unable to obtain the beneficiary's medical records.
- B. The case management agency is responsible for locating, coordinating, and monitoring PHRM services.
- C. Enhanced services are provided to the pregnant woman based on health risks identified during the medical risk screening. Services include:
  1. Nutritional assessment/counseling,

2. Psychosocial assessment/counseling,
3. Health education must:
  - a) Be provided by a registered nurse, nurse practitioner, certified nurse-midwife, physician assistant, nutritionist/dietician and/or social worker, either one-on-one or in a group, during pregnancy and the postpartum period
  - b) Not exceed ten (10) times during the pregnancy and postpartum period, and
  - c) Include a written plan or curriculum designed to prevent the development of further complications during pregnancy and provide education that includes:
    - 1) Prenatal care,
    - 2) Danger signs in pregnancy,
    - 3) Labor and delivery,
    - 4) Nutrition,
    - 5) Pregnancy risk reduction, and
    - 6) Reproductive health.
4. Home visits must:
  - a) Be provided by a registered nurse, nurse practitioner, certified nurse mid-wife, physician assistant, nutritionist/dietitian, and/or social worker during pregnancy as part of the assessment and follow-up,
  - b) Not exceed a maximum of five (5) visits, with at least one (1) during the postpartum period. A registered nurse must make the postpartum home visit, and
  - c) Be recorded in the progress notes and on the Patient Tracking Form.

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

*Rule 2.4: High Risk Infants*

- A. The Division of Medicaid defines high risk infants as those whose medical status during their first (1<sup>st</sup>) year of life places them at risk for morbidity or mortality.
- B. An infant medical risk screening must be completed by a physician, physician assistant, certified nurse-midwife, or a nurse practitioner to determine if the infant is high risk for mortality or morbidity.

1. An infant is considered high risk if one (1) or more risk factors are indicated.
  2. An infant is limited to two (2) medical risk assessments.
- C. The case manager will coordinate enhanced services with needed medical services. Children who are eligible for early intervention should be referred immediately to the Mississippi State Department of Health's Early Intervention program First Steps.
- D. Enhanced services are provided to high risk infants through the EPSDT program and include:
1. Nutritional assessment/counseling.
  2. Psychosocial assessment/counseling.
  3. Health Education must:
    - a) Be provided to the family of the infant in a one-on-one setting,
    - b) Include a written plan or curriculum designed to prevent the development of complications and identifying early signs and symptoms of disease, and
    - c) Be provided by a registered nurse, nurse practitioner, certified nurse-midwife, physician assistant, nutritionist/dietitian or social worker.
  4. Home visits must:
    - a) Be provided at the infant's place of residence as part of the assessment and follow-up,
    - b) Be provided by a registered nurse, nurse practitioner, certified nurse-midwife, physician assistant, nutritionist/dietitian, or social worker, and
    - c) Be documented in the progress notes and recorded on the Patient Tracking Form.

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

*Rule 2.5: Plan of Care*

- A. A plan of care must be developed and implemented for problems identified from the detailed enhanced services assessment.
- B. A PHRM/ISS case manager must be assigned.
  1. The case manager must be a physician, physician assistant, registered nurse, nurse practitioner, certified nurse-midwife, social worker, or nutritionist/dietitian.

2. The nutritionist/dietitian may only serve as the case manager if the enrollee's primary risk is nutritional problems.

C. The case manager along with the PHRM/ISS team members must review the plan of care monthly to determine if the desired outcomes were achieved by the target date. If not, a revised plan of care must be implemented.

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

*Rule 2.6: Medical Record Documentation Requirements*

PHRM/ISS medical record documentation must contain the following on each patient:

A. Signed consent for treatment,

B. Date of service,

C. Demographic information including:

1. Name,

2. Address,

3. Medicaid number,

4. Date of birth,

5. Sex, and

6. Marital status.

D. Past and present medical history,

E. Family history,

F. Allergies including:

1. Type,

2. Reaction, and

3. Treatment.

G. Medications:

1. Prescribed, and

2. Over-the-counter.

H. Specific name/type of all diagnostic studies with the results/findings,

I. Physical findings,

J. Signed physician orders, treatments, and procedures rendered,

K. Maternity services including:

1. Initial assessment,
2. Second trimester updates,
3. Hospital postpartum/discharge summary,
4. Emergency room reports, and
5. Specialty referrals.

L. Infant services including:

1. Injuries and hospitalizations,
2. Hospital admission/discharge summary,
3. Emergency room reports,
4. Operations,
5. Major illnesses,
6. Immunizations,
7. Physical examination,
8. EPSDT program services, and
9. Specialty referrals.

Source: Miss. Code Ann. § 43-13-12143-13-117; 43-13-118; 43-13-129

*Rule 2.7: 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