Title 23: Division of Medicaid

Part 222: Maternity Services

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.