

Title 23: Division of Medicaid

Part 222: Maternity Services

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 sixty (60) days including any remaining days in the month in which the sixtieth (60th) day 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.

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

History: Revised eff. 01/02/2015.

Rule 1.2: [Reserved]

History: Removed eff. 01/02/2015.

Rule 1.5: [Reserved]

Source: Miss. Code Ann. § 43-13-121.

History: Removed eff. 01/02/2015.

Title 23: Division of Medicaid

Part 222: Maternity Services

~~Part 222~~ Chapter 1: General

Rule 1.1: Maternity Services

A. The Division of Medicaid covers maternity services which include: ~~all antepartum care, the delivery, and postpartum services.~~

1. ~~Medicaid defines a~~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. ~~Medicaid defines d~~Delivery services defined by the Division of Medicaid as the care involved in labor and delivery,~~the actual birth and continues for two (2) months following the month of the birth of the newborn.~~
3. ~~Medicaid defines p~~Postpartum services defined by the Division of Medicaid as the care of the mother services inclusive of both hospital and office visits following delivery for sixty (60) days including 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 (60th) day falls occurs.~~

~~B. Reporting is required for hospital admissions for obstetrical deliveries.~~

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.

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

History: Revised eff. 01/02/2015.

Rule 1.2: ~~Multiple Birth Deliveries~~ [Reserved]

~~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 (2nd) 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~~

~~History: Removed eff. 01/02/2015.~~

~~Rule 1.5: *Billing for Maternity Services*[Reserved]~~

~~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~~

~~History: Removed eff. 01/02/2015.~~