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:

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.

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

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