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.

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.