



Mississippi Medicaid
Provider Reference Guide
For Part 222
Maternity

*This is a companion document to the
Mississippi Administrative Code Title 23
and must be utilized as a reference only.*

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Maternity Services Introduction

Medicaid, as authorized by Title XIX of Social Security Act (SSA), Section 1902 (e) 5 is a federal and state program of medical assistance to qualified individuals. This program covers prenatal services for pregnant women, as determined under the provision of the Mississippi Medical Assistance Act to categorically needy individuals. Each state designates a state agency for the administration of Medicaid. State law has designated the Division of Medicaid, Office of the Governor, as the single state agency to administer the program in Mississippi.

Pregnancy-related services are those services that are necessary for the health of the pregnant woman and fetus, or that have become necessary as a result of the woman having been pregnant. The purpose is to ensure that every pregnant woman has access to prenatal care with the goal of lowering Mississippi's infant mortality rate and overall improving maternal and infant health.

Maternal/Fetal Ultrasound

Ultrasonography is a procedure used to visualize the shape of various tissues and organs in the body through the use of intermittent low-intensity sound waves directed into the tissues. Ultrasonography during pregnancy is used to assess the umbilical cord, placenta, fetal movements, internal organs, and the status of the fetus during pregnancy.

Ultrasonography during Hospitalization

When a pregnant beneficiary is hospitalized as an inpatient and a physician submits a claim for both a visit and for review of an ultrasound, on the same date of service, reimbursement will only be provided for the visit as the review of diagnostic studies is inclusive in the CPT Evaluation and Management code for the subsequent hospital visits.

A physician's interpretation of the results of an ultrasound will be reimbursed as a separate service if prepared with a separate distinctly identifiable signed written report using the appropriate CPT code with the modifier 26 which indicates professional component only. This clarification of policy is effective for dates of services on and after July 1, 2001.

Medically Necessary Ultrasonography

Clinical conditions for which reimbursement will be allowed include the following (this list is not all inclusive and other conditions that meet all of the above medical necessity criteria may also be reimbursed):

- To assess a discrepancy in clinical estimates of fetal size versus fetal age

- To assess vaginal bleeding of undetermined etiology during pregnancy
- To confirm suspected abnormal fetal position, e.g., breech or transverse
- To confirm suspected multiple gestation based on detection of more than one (1) fetal heartbeat pattern, or fundal height larger than expected for dates, and/or prior use of fertility drugs
- To confirm suspected hydatidiform mole on the basis of clinical signs of hypertension, proteinuria, and/or the presence of ovarian cysts felt on pelvic examination, or failure to detect fetal heart tones with a Doppler ultrasound device after twelve (12) weeks
- To confirm suspected fetal death
- To confirm suspected uterine abnormality
- To confirm suspected polyhydramnios or oligohydramnios
- To assess placental localization associated with abnormal bleeding
- To estimate fetal weight and/or presentation in premature rupture of membranes and/or nonvertex presentation and/or premature labor
- To provide guidance for other testing, such as amniocentesis, chorionic villus sampling, and cordocentesis
- History of cervical cerclage incompetence and/or cervical cerclage placement
- To evaluate and/or re-evaluate, serially if necessary, a pelvic mass that has been detected clinically
- To localize intrauterine contraceptive device
- To assess suspected abruptio placentae
- As an adjunct to external version from breech to vertex presentation
- To assess fetus following abnormal serum alpha-fetoprotein (AFP) value for clinical gestational age

- To provide an estimation of gestational age for beneficiaries with clinically significant uncertain delivery dates, or verification of dates no later than end of second trimester
- To observe intrapartum events (e.g., version or extraction of second twin, manual removal of placenta, etc.)
- History of previous congenital anomaly or as follow up observation of identified fetal anomaly
- To provide serial evaluation of fetal growth in multiple gestation. The most relevant clinical information is obtained when serial exams are done at least three (3) weeks apart, beginning no earlier than 16 to 18 weeks gestation
- To evaluate fetal condition in late registrants for prenatal care
- To evaluate fetal growth when the beneficiary has an identified etiology for uteroplacental insufficiency (chronic systemic diseases such as diabetes, chronic hypertension, cardiac disease, renal disease, pregnancy induced hypertension, etc.)
- To confirm suspected ectopic pregnancy or when pregnancy occurs after tuboplasty or prior ectopic gestation
- Habitual abortion
- To evaluate post-maturity
- To evaluate neural tube defect
- To evaluate fetal arrhythmias
- To perform follow-up evaluation of placenta location for identified placenta previa
- To evaluate macrosomia or IUGR

Documentation

All professional and institutional providers participating in the Medicaid program are required to maintain records that will disclose services rendered and billed under the program and, upon request, make records available to representatives of DOM or Office of Attorney General in substantiation of any or all claims. These records should be retained a minimum of five (5) years in order to comply with all state and federal regulations and laws.

In order for DOM to fulfill its obligations to verify services to Medicaid beneficiaries and those paid for by Medicaid, physicians must maintain auditable records that will substantiate the claim submitted to Medicaid.

A picture displaying at least one (1) or more of these findings would be acceptable. Documentation should reflect the type of obstetrical ultrasound actually performed, limited or complete. A limited obstetrical ultrasound can be performed in an office setting and may include any or all of the following studies:

- Pregnancy determination
- Viability of heartbeat
- Fetal age or growth rate
- Fetal position
- Placental localization
- Multiple gestations

The complete obstetrical ultrasound involves a more complex study that requires sophisticated equipment and a more experienced ultra-sonographer. The complete studies can also be performed in an office setting with appropriate equipment and training of the physician. The beneficiary's record should contain information that verifies the performance of a complete ultrasound. This information should include all of the following:

- Fetal measurements
- Fetal position
- Placental location
- Amniotic fluid assessment or measurement

Providers must maintain proper and complete documentation to verify services provided. The provider has full responsibility for maintaining documentation to justify the services provided. DOM and/or fiscal agent have the authority to request any patient records at any time to conduct a random sampling review and/or documentation of any services billed by the provider.

If a provider's records do not substantiate services paid for under the Mississippi Medicaid program, as previously noted, the provider will be asked to refund to the Mississippi Medicaid program any money received from the program for such non-substantiated services. If a refund is not received within 30 days, a sum equal to the amount paid for such services will be deducted from any future payments that are deemed to be due to the provider.

A provider who knowingly or willfully makes, or causes to be made, false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under federal and state criminal laws. A false attestation can result in civil monetary penalties as well as fines, and may automatically disqualify the provider as a provider of Medicaid services.

Billing for Maternity Service

Effective for dates of services on and after October 1, 2003, the Division of Medicaid will reimburse delivering physicians for maternity services provided to eligible Medicaid beneficiaries according to the following guidelines:

- Providers may not bill local codes W6140, W6130, and W6150 that were used to reimburse antepartum visits. In accordance with HIPPA regulations these codes are no longer valid and should not be billed.
- Providers must utilize CPT evaluation and management codes 99201 through 99215, 59425 and 59426 to bill antepartum visits as listed below:
 - Providers must bill CPT Codes in the 99201 through 99215 range for antepartum visits 1 or 2 or 3. Bill one code per visit.
 - Providers must bill CPT code 59425 for antepartum visits 4, 5, or 6. Bill one code per visit.
 - Providers must bill CPT code 59426 for antepartum visits 7 or over. Bill one code per visit.

The number of the antepartum visit is defined as the number of visit(s) the beneficiary has made to one physician.

For example, a beneficiary goes to Dr. A for antepartum visits 1, 2, 3, and 4 and then goes to Dr. B. Dr. A will bill the appropriate evaluation and management code for each antepartum visit 1, 2, 3, and CPT code 59425 for antepartum visit 4. Dr. B will then bill for his antepartum visit starting with antepartum visit number (one). If Dr. B is in the same group he will not start over using the appropriate E&M code but will continue with the antepartum code for visit 4.

For dates of service on and after October 1, 2003, CPT codes 59410, 59515, 59614 and 59622 will be used to reimburse deliveries and postpartum care. The postpartum care is inclusive of both hospital and office visits following vaginal and cesarean section deliveries.

CPT codes 59409, 59514, 59612, and 59620 can be used for reimbursement of delivery only. This code should be used by a physician who only completes the delivery, and provides no other service.

DOM will accept CPT code 59430 which is used to reimburse the postpartum hospital and office visits. It should be used only when the physician did not perform the delivery and is billing only for both inpatient and office postpartum visits. In most instances DOM expects this code to be used in rare circumstances. This code cannot be utilized by physicians in the same group as the delivery physician.

Physicians may bill the appropriate CPT E & M code for reimbursement when the postpartum office visit is the only service provided by the physician.

Modifier TH identifies “obstetrical treatment/services, prenatal and postpartum” and must be reported with each code for antepartum visits and deliveries and postpartum care. The Division of Medicaid will utilize this modifier to track data and to bypass the physician visit limitation of twelve (12) visits per fiscal year. Antepartum office visits will not be subject to this limitation.

CPT Code	Billing Instructions
99201 – TH	Bill for dates of service on and after 10/01/03 only if appropriate to bill antepartum visit 1 or 2 or 3. Bill one code per visit.
99202 – TH	Bill for dates of service on and after 10/01/03 only if appropriate to bill antepartum visit 1 or 2 or 3. Bill one code per visit.
99203 – TH	Bill for dates of service on and after 10/01/03 only if appropriate to bill antepartum visit 1 or 2 or 3. Bill one code per visit.
99204 – TH	Bill for dates of service on and after 10/01/03 only if appropriate to bill antepartum visit 1 or 2 or 3. Bill one code per visit.
99205 – TH	Bill for dates of service on and after 10/01/03 only if appropriate to bill antepartum visit 1 or 2 or 3. Bill one code per visit.
99211 – TH	Bill for dates of service on and after 10/01/03 only if appropriate to bill antepartum visit 1 or 2 or 3. Bill one code per visit.
99212 – TH	Bill for dates of service on and after 10/01/03 only if appropriate to bill antepartum visit 1 or 2 or 3. Bill one code per visit.
99213 – TH	Bill for dates of service on and after 10/01/03 only if appropriate to bill antepartum visit 1 or 2 or 3. Bill one code per visit.
99214 – TH	Bill for dates of service on and after 10/01/03 only if appropriate to bill antepartum visit 1 or 2 or 3. Bill one code per visit.
99215 – TH	Bill for dates of service on and after 10/01/03 only if appropriate to

	bill antepartum visit 1 or 2 or 3. Bill one code per visit.
59400 – TH	Closed
59409 – TH	Bill for dates of service on and after 10/01/03 only if physician performs the delivery with no other services.
59410 – TH	Bill for dates of service on and after 10/01/03.
59425 – TH	Bill for dates of service on and after 10/01/03 for each antepartum visit 4, 5 or 6.
59426 - TH	Bill for dates of service on and after 10/01/03 for each antepartum visit 7 and over.
59430 – TH	Bill for dates of service on and after 10/01/03 when the physician did not perform the delivery and is billing only for inpatient and office postpartum visits.
59510 – TH	Closed
59514 – TH	Bill for dates of service on and after 10/01/03 only if physician performs the delivery with no other services.
59515 – TH	Bill for dates of service on and after 10/01/03.
59610 – TH	Closed
59612 – TH	Bill for dates of service on and after 10/01/03 only if physician performs the delivery with no other services.
59614 – TH	Bill for dates of service on and after 10/01/03.
59618 – TH	Closed
59620 – TH	Bill for dates of service on and after 10/01/03 only if Physician performs the delivery with no other services.
59622 – TH	Bill for dates of service on and after 10/01/03.

Rural Health Clinics (RHC), Federally Qualified Health Centers (FQHC), and Mississippi State Department of Health (MSDH) will be reimbursed according to the reimbursement methodology that applies to the clinic, with encounter rate or fee for service, whichever is applicable.

Perinatal High Risk Management and Infant Services Introduction

Medicaid, as authorized by Title XIX of the Social Security Act, is a federal and state program of medical assistance to qualified individuals. Each state designates a state agency as the single state agency for the administration of Medicaid. State law has designated the Division of

Medicaid, Office of the Governor, as the single state agency to administer the Medicaid program in Mississippi.

The Perinatal High Risk Management/Infant Services System (PHRM/ISS) program is a multidisciplinary case management program established to improve access to health care and to provide enhanced services to certain Medicaid eligible pregnant/postpartum women and infants. The enhanced services for this target population are case management, psychosocial and nutritional assessment/counseling, home visits, and health education. Participating providers must employ or have access to an interdisciplinary team that consists of the following:

- Mississippi licensed physician, physician assistant, nurse practitioner, certified nurse-midwife or registered nurse
- Mississippi licensed social worker
- Mississippi licensed nutritionist or registered dietitian.

A PHRM/ISS provider's participation in the Mississippi Medicaid program is entirely voluntary. However, if a provider does choose to participate in Medicaid, the provider must accept the Medicaid payment as payment in full for those services covered by Medicaid. The provider cannot charge the beneficiary the difference between the usual and customary charge and Medicaid payment. The provider cannot accept payment from the beneficiary, bill Medicaid, and then refund the Medicaid payment to the beneficiary. Services not covered under the Medicaid program can be billed directly to the Medicaid beneficiary.

The Mississippi Medicaid program purchases needed health care services for beneficiaries as determined under the provision of the Mississippi Medical Assistance Act. DOM is responsible for formulating program policy. DOM staff is directly responsible for the administration of the program. Under the direction of DOM, the fiscal agent is responsible for processing claims, issuing payments to providers, and for notifications regarding billing. Medicaid policy as it relates to these factors is initiated by DOM.

High Risk Pregnant Women

Target Population

Pregnant women whose pregnancies may be complicated by health factors resulting in adverse outcomes for themselves and/or their unborn children.

Maternity Medical Risk Screening

The medical risk screening is completed by a physician, physician assistant, a nurse practitioner, or a certified nurse-midwife. During any one pregnancy, the beneficiary may be assessed for medical risk twice. A second assessment is necessary only if the beneficiary changes providers and the new provider is unable to obtain her medical records.

A beneficiary qualifies for PHRM services if one or more positive risk factors are identified on the Maternity Risk Screening Form. For the convenience of physicians using the Hollister record system, the Hollister health history item number has been “translated” to the Maternity Risk Screening Form.

The provider has the option of entering the beneficiary into his/her own high risk case management agency or referring the beneficiary to an appropriate case management agency.

Case Management

Case management is a set of interrelated activities under which an assigned person in the case management agency has the responsibility for locating, coordinating, and monitoring services in order to assist the beneficiary in gaining access to needed medical, social, educational, and other services. The ultimate goals are to reduce the complications of identified risks during pregnancy, to reduce the occurrence of low birth weight infants, infant mortality or morbidity, to encourage the use of cost effective medical care by appropriate and timely referrals, and to discourage over utilization or duplication of costly services.

Once referred, the beneficiary may receive a package of enhanced services throughout pregnancy and for sixty days postpartum.

Enhanced Services

Enhanced services are provided to the pregnant woman based on health risks identified during the medical risk assessment. Services include nutrition assessment/counseling, psychosocial assessment/counseling, health education, and home visits.

Nutritional Assessment/Counseling

Nutritional assessment is a review of the high risk pregnant/postpartum woman’s dietary pattern and intake, her resources for obtaining and preparing food, and evaluation of her nutritional needs. A complete nutritional assessment includes an examination of anthropometric, biochemical, clinical, dietary, and economic/social/cultural data.

Counseling services include developing a nutritional care plan based on the health risks identified due to nutritional factors.

Psychosocial Assessment/Counseling

Psychosocial assessment is an evaluation of the high risk beneficiary and her environment to identify social and behavioral factors that may impact the beneficiary, thereby adversely affecting the pregnancy outcome.

Counseling services include developing a social work care plan based on the health risks due to psychosocial factors.

Home Visits

Home visits are provided during pregnancy at the beneficiary's place of residence as part of the assessment and follow-up. The purpose of home visits is to evaluate environmental factors that may adversely affect the beneficiary. A registered nurse, nurse practitioner, certified nurse midwife, physician assistant, nutritionist/dietitian, and/or social worker may provide this service. At least one home visit is required during the postpartum period. A registered nurse must make the postpartum home visit.

Home visits must be recorded in the progress notes. Home visit appointments must be recorded on the Patient Tracking Form.

Covered Services for High Risk Pregnant Women

Medicaid will reimburse high-risk case management agencies for case management enhanced services to pregnant women using the procedure codes and limits as follows:

CODE	DESCRIPTION	LIMITS	PROVIDER TYPE(S)
T1023	Maternal Medical Risk Screen	* 1 encounter per pregnancy	Physician, Midwife, Nurse Practitioner, or Physician Assistant
H1002-TH	Initial Case Management	*1 encounter per pregnancy	Case Manager

T1017-TH	Maternal Case Management	9 encounters per pregnancy	Case Manager
S9470-TH	Nutritional Assessment/ Counseling	8 encounters per pregnancy S9470- TH and H0023-TH encounters may be in any combination but may not exceed a total of eight (8).	Case Manager
H0023-TH	Psychosocial Assessment/ Counseling	Note: S9470-TH and H0023-TH must be face-to-face.	
S9445-TH	Health Education	10 encounters per pregnancy. May be one-on-one or group.	Case Manager
S9123-TH	In-Home Registered Nurse	5 encounters per pregnancy S9123-TH, S9470-TH, and S9127-TH encounters may be in any combination but may not exceed a total of five (5). Exception: One must be an actual visit in the home by a registered nurse.	Case Manager
S9470-TH	In-Home Nutritionist		
S9127-TH	In-Home Social Worker		

* One additional medical risk screen or initial case management screen allowed if the beneficiary changes to a new provider and the provider cannot obtain records.

Codes will generate an encounter payment for the State Department of Health and Federally Qualified Healthcare Centers and fee-for-service to individual and group providers.

High Risk Infants

Case Management

Case management is a set of interrelated activities under which responsibility for locating, coordinating, and monitoring appropriate services for an individual rests with a specific person within the case management agency in order to assist the beneficiary in gaining access to needed medical, social, educational, and other services. The ultimate goals are to reduce the complications of identified risks, to reduce infant mortality or morbidity, to encourage the use of cost effective medical care by referrals to appropriate providers, and to discourage over utilization or duplication of costly services. 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 Early Intervention program, First Steps.

Enhanced Services

Enhanced services are provided to high risk infants through the EPSDT program.

Nutritional Assessment/Counseling

Nutritional assessment is a review of the high risk infant's nutritional needs.

Counseling services include developing a nutritional care plan based on identified nutritional health risks and coordinating with Special Supplemental Food Program for Women, Infants, and Children (WIC), if the beneficiary is WIC eligible.

Psychosocial Assessment/Counseling

Psychosocial assessment is an evaluation of the high risk infant and his/her environment to identify psychosocial factors that may adversely affect the infant's health status.

Counseling services include developing a social work care plan based on the health risks due to psychosocial factors. It also includes follow-up, appropriate intervention and referrals to carry out the social work care plan.

Health Education

Health education is provided to the family of the infant in a one-on-one setting. It includes a written plan or curriculum and is designed to prevent the development of complications, identifying early signs and symptoms of disease, etc. A registered nurse, nurse practitioner, certified nurse-midwife, physician assistant, nutritionist/dietitian or social worker may provide this service.

Home Visits

Home visits are provided at the infant's place of residence as part of the assessment and follow-up. The purpose of the home visit is to evaluate environmental factors that may adversely affect the infant. A registered nurse, nurse practitioner, certified nurse-midwife, physician assistant, nutritionist/dietitian, or social worker may provide this service.

Home visits must be documented in the progress notes. Home visit appointments must be recorded on the Patient Tracking Form.

Covered Services for High Risk Infants

Medicaid will reimburse high risk case management agencies for case management enhanced services to infants using the procedure codes and limits listed below:

CODE	DESCRIPTION	LIMITS
EPSDT EXAMINATIONS UP TO ONE YEAR OF AGE		
99381 or 99391-EP	0-1 month	1 exam
99381 or 99391-EP	2 months	1 exam
99381 or 99391-EP	4 months	1 exam
99381 or 99391-EP	6 months	1 exam
99381 or 99391-EP	9 months	1 exam
99382 or 99392-EP	12 months	1 exam
HIGH RISK INFANT SERVICES		
T1017-EP	High Risk Management	Monthly
S9470-EP	Nutritional Counseling	1 of 6 extra screens
H0023-EP	Psychological Counseling	1 of 6 extra screens

S9445-EP	Health Education	1 of 6 extra screens
S9123-EP	In-Home Nurse Visits	1 of 6 extra screens
S9470-EP	In-Home Nutritionist	1 of 6 extra screens
S9127-EP	In-Home Social Worker	1 of 6 extra screens
T1023	Risk Screening	2 done in the first year of life

For questions regarding this program contact:

Division of Medicaid
EPSDT
Walter Sillers Building
550 High Street, Suite 1000
Jackson, MS 39201
Phone: 601-359-6150 Fax: 601-359-6147

Plan of Care

An appropriate plan of care must be developed and implemented for problems identified from the detailed enhanced services assessment. A case manager must be assigned. The case manager along with the PHRM/ISS team members must review the plan of care monthly to determine if the plan produced the desired outcome by the target date. If not, a revised plan should be implemented.

Role of the PHRM/ISS Case Manager

The PHRM/ISS case manager may be a physician, physician assistant, registered nurse, nurse practitioner, certified nurse-midwife, social worker, or nutritionist / dietitian.

Note: The nutritionist/dietitian may serve as case manager only for enrollees for whom nutritional problems are their primary risk.

The case manager's primary role and responsibility is to ensure that the beneficiary receives needed services by performing the following activities.

- A. Organize and prioritize needs/problems list by reviewing the risk assessment, initial interview referral/enrollment, and service plan
- B. Coordinate care
 - 1. Serve as liaison between beneficiary and all individuals/agencies involved in care at least monthly
 - 2. Serve as contact person for beneficiary/family
 - 3. Communicate status/outcomes to appropriate medical and/or other providers at least monthly
 - 4. Serve as liaison during transition to ongoing health/social services sixty (60) days after delivery for pregnant/postpartum women and one (1) year for infants.
- C. Ensure appropriate/accessible plan of care
 - 1. Health education
 - 2. Nutrition counseling
 - 3. Social services
 - 4. Other human service needs (eligibility for public assistance, day care, transportation, etc.)
 - 5. Home visits
 - 6. Continuum of care-prenatal through labor and delivery to postpartum and infant care
- D. Follow-up
 - 1. Referral-information provided and received in a timely manner
 - 2. Referral to community services (WIC, family planning, and child health)
 - 3. Tracking
 - a. Missed appointments
 - b. Identification and resolution barriers

c. Rescheduling

Documentation Timeline for PHRM/ISS Service

High risk pregnant women and infants who have been identified with a positive risk screen must be enrolled within seven (7) to ten (10) days after the risk screen is completed. This includes completion of the PHRM/ISS Initial Enrollment Form in its entirety and obtaining a signature on the letter of agreement to participate in the PHRM/ISS program.

The Perinatal High Risk Management/Infant Services System (PHRM/ISS) assessment components (medical, psychosocial, and nutritional) must be completed in detail within six (6) weeks and no later than eight (8) weeks after the initial enrollment is completed.

The postpartum home visit must be made by a registered nurse or designated medical professional within two (2) weeks post-delivery.

Case closure documentation for high risk pregnant women at sixty (60) days postpartum and high risk infants at one (1) year and under must reflect all case management activities conducted to resolve the identified risk(s) as well as address outcomes/final status at time of closure.

Medical Record Documentation Requirements

All professional and institutional providers participating in the Medicaid program are required to maintain records that will disclose services rendered and/or billed under the program and, upon request, make such records available to representatives of DOM to substantiate any or all claims. These records must be retained a minimum of five (5) years to comply with all state and federal regulations and laws.

In order for DOM to fulfill its obligations to verify services rendered to Medicaid beneficiaries and paid for by Medicaid, the provider must maintain legible and auditable records that will substantiate the claim submitted to Medicaid. At a minimum, PHRM/ISS medical record documentation must contain the following on each patient:

- Signed consent for treatment;
- Date of service

- Demographic information (name, address, Medicaid number, date of birth, sex, marital status, etc.);
- Medical history (past and current);
- Family history when appropriate;
- Allergies (type, reaction, and treatment);
- Medications (prescribed and/or over-the-counter);
- Specific name/type of all diagnostic studies (example: laboratory, radiology, ECG when appropriate) and the result/finding of the studies;
- Physical findings;
- Signed physician orders, treatments, and procedures rendered;
- Maternity services (initial assessment, second trimester updates, hospital postpartum/discharge summary, emergency room reports, specialty referrals, etc.);
- Infant services (injuries and hospitalizations, operations, major illnesses, immunizations, physical examination, EPSDT program services, emergency room reports, hospital admission/discharge summary, specialty referrals, etc.)

Providers must maintain proper and complete documentation to verify services provided. The provider has full responsibility for maintaining documentation to justify the services provided.

DOM, the Utilization Management and Quality Improvement Organization, and/or the fiscal agent have the authority to request patient records at any time to conduct a random review and/or documentation of services billed by the provider.

If a provider's records do not substantiate services paid for under the Mississippi Medicaid Program, as previously noted, the provider will be asked to refund to the Mississippi Medicaid Program any money received for such nonsubstantiated services. If a refund is not received within thirty (30) days, a sum equal to the amount paid for such services will be deducted from any future payments that are deemed to be due to the provider.

A provider who knowingly or willfully makes or causes to be made, false statements or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under federal and state criminal laws. A false attestation can result in civil

monetary penalties as well as fines, and may automatically disqualify the provider as a provider of Medicaid services.