

CHAPTER 58

NURSE-MIDWIFERY SERVICES

Authority

N.J.S.A. 30:4D-6a(5)(b)(3)(17), 7, 7a, b and c; 12; 1905(a)(17) of the Social Security Act; 42 CFR 440.165.

Source and Effective Date

R.1991 d.153, effective February 22, 1991.
See: 22 N.J.R. 3613(a), 23 N.J.R. 858(c).

Executive Order No. 66(1978) Expiration Date

Chapter 58, Nurse-Midwifery Services, expires on February 22, 1996.

Chapter Historical Note

Chapter 58, Nurse-Midwifery Services, was formerly the Independent Clinic Services Manual, and was filed and became effective on April 21, 1971 as R.1971 d.54. See: 3 N.J.R. 42(b), 3 N.J.R. 82(c). Additional rules on this subject were codified as N.J.A.C. 10:66 and were filed on August 16, 1973 as R.1973 d.228 to become effective on October 1, 1973. See: 5 N.J.R. 226(c), 5 N.J.R. 339(b). Amendments effective October 26, 1976 as R.1976 d.335 and codified to N.J.A.C. 10:58-1.1 were miscodified and should have amended N.J.A.C. 10:66-1.4. Chapter 58 was repealed by R.1980 d.351, filed and effective on August 7, 1980. See: 12 N.J.R. 413(b), 12 N.J.R. 536(d). Chapter 58 became effective as R.1982 d.415, effective December 6, 1982 (operative January 1, 1983). See: 14 N.J.R. 889(a), 14 N.J.R. 1393(a). Pursuant to Executive Order No. 66(1978), Chapter 58 was readopted as R.1991 d.153. See: Source and Effective Date.

See subchapter and section annotations for specific rulemaking activity.

CHAPTER TABLE OF CONTENTS

SUBCHAPTER 1. GENERAL PROVISIONS

- 10:58-1.1 Nurse-midwifery
- 10:58-1.2 Definitions
- 10:58-1.3 Scope of service
- 10:58-1.4 Basis of payment
- 10:58-1.5 Provisions for participation
- 10:58-1.6 Supplies and equipment
- 10:58-1.7 Medication dispensing policy
- 10:58-1.8 Recordkeeping

SUBCHAPTER 2. BILLING PROCEDURES

- 10:58-2.1 General billing procedures
- 10:58-2.2 Timeliness of claim submission and claim inquiry
- 10:58-2.3 Health Insurance Claim Form
- 10:58-2.4 Mailing instructions

SUBCHAPTER 3. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

SUBCHAPTER 1. GENERAL PROVISIONS

10:58-1.1 Nurse-midwifery

This chapter is concerned with the provisions of health care services by certified nurse-midwives, in accordance with the New Jersey Medicaid Program Provider Agreement and the minimal standards as set forth by the New Jersey Board of Medical Examiners, N.J.A.C. 13:35-2.6 through 2.14.

Amended by R.1991 d.153, effective March 18, 1991.

See: 22 N.J.R. 3613(a), 23 N.J.R. 858(c).
Revised N.J.A.C. citations.

10:58-1.2 Definitions

The following words and terms, when used in the chapter shall have the following meanings unless the context clearly indicates otherwise.

“Certified nurse-midwife” (C.N.M.) means a registered professional nurse licensed in New Jersey who, by virtue of added knowledge and skill gained through an organized program of study and clinical experience, receives certification by the American College of Nurse-Midwives. A C.N.M. shall be licensed by and registered with the New Jersey Board of Medical Examiners.

“HealthStart Maternity (Comprehensive) Care Services Provider” means a midwife who provides either directly or indirectly through linkage with other health care providers, in independent clinics and hospital outpatient departments; or physicians’ offices, a comprehensive package of maternity care services which includes two components, “Medical Maternity Care” and “Health Support Services.” (See N.J.A.C. 10:49-3 for information about HealthStart Services and provider requirements for participation).

“Maternity (Comprehensive) Care Services” under HealthStart means a comprehensive package of maternity care services which includes two components, “Medical Maternity Care” and “Health Support Services”. (See N.J.A.C. 10:49-3 for information about HealthStart Services and provider requirements for participation.)

“Nurse-midwifery services” means those services provided to manage the care of essentially normal newborns at the time of delivery and essentially normal women during the maternity cycle. Nurse-midwifery services must be provided within the scope of practice of the nurse-midwifery profession as defined by the laws and regulations of the State of New Jersey.

“The maternity cycle” means a time period limited to pregnancy, labor, birth and the immediate 60 day postpartum period.

Amended by R.1988 d.62, effective February 1, 1988.

See: 19 N.J.R. 1978(a), 20 N.J.R. 278(b).

Added definitions "HealthStart Maternity (Comprehensive) Care Services Provider" and "Maternity (Comprehensive) Care Services". Amended by R.1989 d.162, effective March 20, 1989. See: 20 N.J.R. 1052(a), 21 N.J.R. 761(a).

Postpartum period changed from six weeks to 60 days.

10:58-1.3 Scope of service

(a) A certified nurse-midwife may, to the extent of her/his license and approved New Jersey Medicaid Program Provider Agreement, provide those obstetrical services required to manage the care of mothers and newborns throughout the maternity cycle.

(b) A C.N.M. shall not work alone in an individual or independent practice but shall function within a health care system which provides for consultation, collaborative management and referral with a physician licensed to practice medicine and surgery in the State of New Jersey.

(c) A certified nurse-midwife shall have, by virtue of her or his license, a written agreement(s) with one or more licensed physicians in the State of New Jersey who practice obstetrics and who have hospital privileges in that field. The agreement must conform to the requirements of N.J.A.C. 13:35-9.3(a)1-5 as currently exists or as hereinafter may be amended.

(d) For HealthStart Maternity (Comprehensive) Health Services rules see N.J.A.C. 10:49-3 for information about HealthStart Services and provider requirements for participation.

(e) Family planning services may be provided including medical history and physical examination (including pelvic and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision, continuity of care and genetic counseling.

1. Services provided primarily for the diagnosis and treatment of infertility, including related office visits, drugs, laboratory services, radiological and diagnostic services and surgical procedures are not covered by the New Jersey Medicaid program.

i. Exception: When a service is provided that is ordinarily considered an infertility service, but is provided for another purpose, then the certified nurse midwife must submit the claim with supporting documentation for medical review and approval of payment to the Division of Medical Assistance and Health Services, Office of Medical Affairs and Provider Relations, CN 712, (Mail Code # 14), Trenton, New Jersey 08625-0712.

Amended by R.1988 d.62, effective February 1, 1988.

See: 19 N.J.R. 1978(a), 20 N.J.R. 278(b).

Subsection (d) added.

Amended by R.1994 d.600, effective December 5, 1994.

See: 26 N.J.R. 3345(a), 26 N.J.R. 4762(a).

10:58-1.4 Basis of payment

(a) The New Jersey Medicaid Program shall reimburse a New Jersey licensed/registered certified nurse-midwife for nurse-midwifery services provided in New Jersey.

1. A certified nurse-midwife who has independent provider status, (see N.J.A.C. 10:58-1.5 Provisions for participation), shall be reimbursed directly by the New Jersey Medicaid Program on a fee for service basis in accordance with the nurse-midwifery procedure codes, descriptions and maximum dollar allowances for nurse-midwifery services as listed in the Procedure Code Manual at N.J.A.C. 10:54-3.

2. A certified nurse-midwife shall not be reimbursed as an independent provider by the New Jersey Medicaid Program when the program is required to reimburse an approved provider through another mechanism for these same services, e.g., a hospital salaried C.N.M. whose salary is included in the per diem.

(b) Nurse-midwifery services shall be kept identifiable and distinct from physician obstetrical services by utilization of procedure codes. Therefore, the appropriate procedure code(s) should be used depending upon who rendered the service and separate 1500-N.J. claim forms should be filed. Whenever a claim for reimbursement is filed, the claim form must contain the Individual Medicaid Practitioner (IMP) number of the practitioner who performed the service(s).

(c) The New Jersey Medicaid Program shall reimburse for nurse-midwifery services provided only when the patient is an eligible Medicaid client at the time services are rendered. Medicaid clients should present verification of current eligibility status at each visit.

1. Reimbursement is not made for, and clients may not be asked to pay for, broken appointments.

10:58-1.5 Provisions for participation

(a) The certified nurse-midwife who is eligible for direct reimbursement from the New Jersey Medicaid Program must be individually approved as a provider and obtain a provider number.

1. To become an approved Medicaid provider, the C.N.M. must complete the Medicaid Provider Application (FD-22) and the Provider Agreement (FD-62) and submit these to:

The Prudential Insurance Company
P.O. Box 471
Millville, New Jersey 08332

2. Upon signing and returning the Medical Provider Application, the Provider Agreement and other enrollment documents to the Prudential Insurance Company (a fiscal agent for the New Jersey Medicaid Program), the C.N.M. will receive written notification of approval or disapproval. If approved, the C.N.M. will be assigned an Individual Medicaid Practitioner (IMP) number and added to the Medicaid Director of Practitioners. The Prudential Insurance Company will furnish an IMP number, provider number, provider manual and an initial supply of pre-printed claim forms.

(b) A birthing center must have a current and valid approval from the New Jersey Department of Health and be individually approved as a provider by the New Jersey Medicaid Program before the birthing center will be reimbursed for maternity services.

(c) To become an approved Medicaid provider, the birthing center must complete the Medicaid Provider Application (FD-20), the Provider Agreement (FD-62) and the Ownership and Control Interest and Disclosure Statement (HCFA-1513) and submit these to:

Chief, Provider Enrollment
Division of Medical Assistance and Health Services
CN 712
Trenton, New Jersey 08625

1. Upon signing and returning the Medicaid Provider Application, the Provider Agreement and other enrollment documents to the New Jersey Medicaid Program, the birthing center will receive written notification of approval or disapproval. If approved, the birthing center will be assigned a provider number and added to the Medicaid Directory of Independent Clinics. The Prudential Insurance Company will furnish a provider manual, provider number and an initial supply of pre-printed claim forms.

2. It shall be the responsibility of each approved birthing center to notify the New Jersey Medicaid Program a minimum of 30 days prior to the relocation or closing of its facilities.

10:58-1.6 Supplies and equipment

When the certified nurse-midwife performs a home delivery, the C.N.M. may be reimbursed for a "home delivery pack" (see N.J.A.C. 10:54-4, Procedure Code Manual).

Amended by R.1991 d.153, effective March 18, 1991.
See: 22 N.J.R. 3613(a), 23 N.J.R. 858(c).
Revised N.J.A.C. citations.

10:58-1.7 Medication dispensing policy

All New Jersey licensed certified nurse-midwives shall have, by virtue of their license, established written agreement(s), with one or more licensed physicians in the State of New Jersey who practice obstetrics and who have hospital privileges. This agreement includes a written protocol setting forth standing orders for approved medications which may be dispensed by the C.N.M.

10:58-1.8 Recordkeeping

The certified nurse-midwife in all settings shall keep legible individual records as are necessary to fully disclose the kind and extent of services provided, as well as the medical necessity for those services. Minimum requirements for services performed by the certified nurse-midwife at home, hospital, independent clinic, office or birthing center shall include a progress note in the clinical record for

each visit, except where otherwise specified (e.g., initial visit), which supports the procedure code or codes to be claimed. This information must be available upon the request of the New Jersey Medicaid Program or its agents.

SUBCHAPTER 2. BILLING PROCEDURES

10:58-2.1 General billing procedures

(a) A claim is a bill which indicates a request for payment for a Medicaid-reimbursable service provided to a Medicaid-eligible individual. The claim may be submitted hard copy or by means of an approved method of automated data exchange.

(b) This subchapter contains basic information necessary for the proper completion and submission of a claim.

Amended by R.1987 d.408, effective October 5, 1987.
See: 19 N.J.R. 1155(a), 19 N.J.R. 1800(a).

(a) added; old text became (b).
Amended by R.1991 d.153, effective March 18, 1991.
See: 22 N.J.R. 3613(a), 23 N.J.R. 858(c).

In (b): deleted reference to form 1500-NJ.

10:58-2.2 Timeliness of claim submission and claim inquiry

For timeliness of claim submission and claim inquiry, see N.J.A.C. 10:49-1.12.

New Rule, R.1987 d.408, effective October 5, 1987.
See: 19 N.J.R. 1155(a), 19 N.J.R. 1800(a).
Repealed rule was "General policy".

10:58-2.3 Health Insurance Claim Form

(a) The Health Insurance Claim Form, 1500-N.J., is used for the purposes of billing for covered services of physicians, podiatrists, optometrists, psychologists, chiropractors and certified nurse-midwives.

(b) Instructions for completion of the Health Insurance Claim Form, 1500-N.J., (Exhibit 1) follow:

1. Item 1: Copy the patient's name exactly as it appears on the Validation Form or Medicaid Eligibility Identification Card;
2. Item 2: Indicate patient's date of birth. Use six digit (e.g., Sept. 10, 1980 is written 09/10/80). If only the year is known, enter the year. If actual birthdate is unavailable, enter the patient's age;
3. Item 3: Not applicable to Medicaid;
4. Item 4: Indicate patient's address and telephone number;
5. Item 5: Check appropriate block to identify patient's sex;

6. Item 6: Copy the patient's Medicare I.D. number as it appears on the Medicare Health Insurance Card when the patient is covered by both Medicare and Medicaid;

7. Item 7: Not applicable to Medicaid;

8. Item 8: Copy of the patient's HSP (Medicaid) Case Number and Person Number exactly as it appears on the Validation Form or Medicaid Eligibility Identification Card;

9. Item 9. Check appropriate block to indicate whether the patient has other health insurance coverage. If yes, you must attach a copy of the decline notice or a copy of the explanation of payment;

10. Item 10: Check as appropriate:

- i. If patient's illness or injury is work related; or
- ii. If patient's injury resulted from an automobile accident or other;

11. Item 11: Not applicable to Medicaid;

12. Under ordinary circumstances, the patient must sign the claim form when services have been received. The claim form must indicate services rendered prior to presenting it to the patient for signature. If patient's signature is unobtainable, refer to N.J.A.C. 10:49-1.26;

13. Items 13-18: Not applicable to Medicaid;

14. Item 19: If patient was referred to you, you must indicate the name of the referring practitioner;

15. Item 19a: Enter the Individual Medicaid Practitioner (IMP) Number of the referring practitioner you entered in Item 19;

16. Item 20: Not applicable to Medicaid;

17. Item 21: Write in the name of the institution if place of service is other than office or patient's home. To be completed in addition to Item 24b;

18. Item 21a: Not applicable to Medicaid;

19. Item 22: For C.N.M. services always check "Yes";

20. Item 23a: Enter diagnoses for all services identified in Item 24d;

21. Item 23b: EPSDT Program Referral: Complete this item for recipients under 21 years of age. Ask the patient and/or referring physician or clinic if this visit is a result of an EPSDT screening. Indicate if this patient is such a referral by checking the appropriate block;

22. Item 24a: Enter date(s) of each visit;

23. Item 24b: Identify place of service by selecting appropriate alpha code as listed on the reverse side of form under "Place of Service" Codes. Identify place of service for services performed in a birthing center as "Clinic";

24. Item 24c: Identify type of service by selecting appropriate code as listed on the reverse side of form under "Type of Service Codes";

25. Item 24d: Identify the procedure by code number, as listed in either the Procedure Code Manual or your respective Medicaid Provider Manual, and by a brief corroborative narrative description in the two columns provided under 24d. If a code to describe the service rendered is not provided in the manual, enter an adequate description of the service;

26. Item 24e: Enter reference numbers in (23a) related to applicable diagnosis for that visit;

27. Item 24f: Not applicable to Medicaid;

28. Item 24g: Enter your usual and customary charge for each service or procedure;

29. Item 24h: Check this column for each service ascribable to "Family Planning". These should include visits for infertility studies, oral, mechanical or chemical contraceptives;

30. Item 24i: Leave blank;

31. Item 25: Read the Medicaid Provider Certification on the reverse side of the form carefully. The individual practitioner who personally performed or supervised the service(s) represented on the claim must put his/her signature on each claim before submitting for payment. If a claim covers services performed by more than one practitioner, the group member who performed the last procedure should sign the claim;

Note: (1) Services rendered by a certified nurse-midwife in the employ of a physician or physician group must be billed by the physician/physician group on the 1500-N.J. The appropriate C.N.M. procedure code(s) must be indicated;

(2) If services are provided by more than one type of practitioner, separate claim forms for each type (e.g. physician or C.N.M.) must be submitted for payment, i.e. C.N.M. procedure codes and physician procedure codes may not be placed on the same claim form;

32. Item 26: Not applicable to Medicaid;

33. Item 27: Enter the sum total of the individual charges;

34. Items 28-29: Not applicable to Medicaid;

35. Item 30: Enter the Individual Medicaid Practitioner (IMP) Number of the practitioner actually performing the service described on the claim, i.e. physician or C.N.M.;

36. Item 31: If not preprinted, write provider name, address and provider number; and

37. Items 32-33: Not applicable to Medicaid.

EDITOR'S NOTE: Information concerning Procedure Codes can be obtained from:

Division of Medical Assistance and Health Services
 CN 712
 Trenton, NJ 08625

10:58-2.4 Mailing instructions

For all claims for certified nurse-midwife services, mail the 1500-N.J. to:

The Prudential Insurance Company
 P.O. Box 1900
 Millville, NJ 08332

SUBCHAPTER 3. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

Authority

N.J.S.A. 30:4D-6a(3)(4)b(5); 6b(1)(3)(5)(6)(7)(8)(10)(12)(15)(16);
 7, 7a, 7b, 7c.

Source and Effective Date

R.1986 d.52, effective March 3, 1986.
 See: 17 N.J.R. 1519(b), 18 N.J.R. 478(a).

Editor's Note: The Division of Medical Assistance and Health Services has adopted the HCPCS coding system for the majority of fee-for-service providers participating in the New Jersey Medicaid Program. The HCPCS will not be reproduced in the Code but may be obtained by contacting:

Administrative Practice Officer
 Division of Medical Assistance & Health Services
 Quakerbridge Plaza, Building No. 7
 CN 712
 Trenton, New Jersey 08625
 or
 Office of Administrative Law
 Rules and Publications
 Quakerbridge Plaza, Building No. 9
 CN 301
 Trenton, New Jersey 08625

Public notice: Pursuant to the provisions of N.J.S.A. 30:4D-2, 3, 5, 6 and 7 and the New Jersey Appropriations Act (P.L. 1988 c.47), maximum fee allowance routine visits increased August 1, 1988 and May 1, 1989 and obstetrical services increased May 1, 1988 and April 1, 1989.

See: 20 N.J.R. 2101(a).

Amended by R.1989 d.162, effective March 20, 1989.

See: 20 N.J.R. 1052(a), 21 N.J.R. 761(a).

Post partum period changed from six weeks to 60 days.