

3. Certification from the American College of Nurse Midwives (ACNM) or the American College of Nurse Midwives Council (ACC).

(e) The applicant will receive notification of approval or disapproval from the Medicaid fiscal agent (Unisys). If approved, the CNM shall be furnished with a provider manual and assigned a Medicaid provider identification number. The CNM shall use the assigned provider identification number in all communication with Medicaid and/or the fiscal agent.

#### 10:58-1.5 Application for provider status; HealthStart

(a) A certified nurse midwife who is a Medicaid provider may also become a HealthStart Comprehensive Maternity Care or HealthStart Maternity Medical Care services provider.

(b) In order to participate as a provider of HealthStart services, the CNM practicing independently or as part of a group shall be a Medicaid provider and shall meet the HealthStart requirements specified at N.J.A.C. 10:66-3 and in this chapter. A HealthStart provider shall have a valid HealthStart Provider Certificate:

1. An application for a HealthStart Provider Certificate is available from:

New Jersey Department of Health  
Division of Family Health Services  
50 East State Street, PO Box 364  
Trenton, NJ 08625-0364

#### 10:58-1.6 Application for provider status; birth center

(a) A birth center shall enroll as a CNM provider in order to receive reimbursement for the use of the facility for labor and delivery services provided at the center.

(b) The birth center shall be licensed by the Department of Health and Senior Services in accordance with the provisions of N.J.A.C. 8:43A-28.

(c) In order to receive reimbursement for professional services provided by a CNM employed by the birth center, the birth center shall enroll as a CNM provider and the CNM employed by the birth center shall meet the provider requirements in N.J.A.C. 10:58-1.4(a).

(d) When a CNM not employed by the birth center provides professional services at the birth center as an independent provider, the CNM shall bill Medicaid directly for those professional services.

(e) The birth center shall complete the Medicaid Provider Application (FD-20), the Provider Agreement (FD-62) and the Ownership and Control Interest and Disclosure Statement (HCFA-1513).

1. The birth center shall include with the application a copy of its license, a list of all the CNMs employed by the center, together with their CNM Medicaid provider numbers, and copies of the CNMs' licenses. The application and all attachments shall be submitted to:

Provider Enrollment  
Unisys Corporation  
Mail Code #9  
PO Box 4804  
Trenton, New Jersey 08650-4804

2. Each CNM employed by the birth center shall have a provider servicing number. The birth center shall report this number when billing Medicaid for CNM services.

(f) For information regarding reimbursement for prenatal and post natal care, see N.J.A.C. 10:58-2.16 and 3.6.

(g) Upon signing and returning the Medicaid Provider Application, the Provider Agreement and other enrollment documents to the New Jersey Medicaid program, the birth center will receive written notification of approval or disapproval.

(h) Each approved birth center shall notify the New Jersey Medicaid program a minimum of 30 days prior to the relocation or closing of its facilities.

Amended by R.1998 d.209, effective May 4, 1998.  
See: 30 N.J.R. 57(a), 30 N.J.R. 1613(a).

Rewrote (a); inserted new (b) through (d) and recodified former (b) as (e) and added (e)1 and 2; added a new (f); and recodified former (c) through (d) as (g) through (h).

#### 10:58-1.7 Basis of reimbursement

(a) Reimbursement for certified nurse midwifery services shall be based upon the provider's usual and customary charge or the allowance determined by the Commissioner of the Department of Human Services and contained in N.J.A.C. 10:58-3, whichever is less.

(b) A certified nurse midwife who is approved as a provider of services by the New Jersey Medicaid or the NJ KidCare program and who practices independently and not as part of a physician group or other organized medical care entity, may be directly reimbursed by the New Jersey Medicaid or NJ KidCare program, in accordance with the provisions of this chapter.

(c) The basis for reimbursement of services provided in a birth center is as follows:

1. The birth center shall receive a facility fee of \$1,300, exclusive of laboratory, drugs, and professional fees, for beneficiaries attended on-site during labor and delivery.

2. A birth center shall receive a facility fee of \$500.00, exclusive of laboratory, drugs, and professional fees, for

beneficiaries who are admitted to the birth center in labor but subsequently transferred to a hospital.

3. The HCPCS codes for billing for birth center facility services are described in N.J.A.C. 10:58-3.5(g).

4. A birth center shall be reimbursed for professional CNM services provided by a CNM employed by the birth center in accordance with N.J.A.C. 10:58-1.6(a). The birth center shall not be reimbursed for professional CNM services provided by a CNM who is an independent provider.

5. A physician who provides professional services in a birth center shall bill for his or her services in accordance with N.J.A.C. 10:54-4.33 in order to receive reimbursement for professional services.

6. A birth center billing for laboratory services shall meet all requirements found in N.J.A.C. 10:58-2.9 through 2.13.

7. A birth center billing for medications shall meet all requirements found in N.J.A.C. 10:58-2.17.

8. A birth center may bill for certain injections relative to maternity care or provided to the newborn at the time of delivery, in accordance with N.J.A.C. 10:58-3.5(c).

(d) A certified nurse midwife who is salaried and whose services are part of the hospital's cost shall not bill fee-for-service to the New Jersey Medicaid or NJ KidCare program. A certified nurse midwife who is practicing in a hospital outpatient department and whose reimbursement is not part of the hospital's cost may bill fee-for-service to the New Jersey Medicaid or NJ KidCare program, independent of the hospital charges, if the arrangement with the hospital permits it.

(e) When a certified nurse midwife is employed by a physician, nurse midwifery services shall be identified as separate and distinct from physician services by utilization of procedure codes with the "WM" modifier, as designated under the HCFA Common Procedure Coding System (HCPCS) in N.J.A.C. 10:58-3.

(f) When a certified nurse midwife is employed by a clinic, nurse midwifery services shall be identified by utilization of the procedure code with the "WM" modifier as designated under the HCFA Common Procedure Coding System (HCPCS) in N.J.A.C. 10:66.

(g) For the requirements for HealthStart Maternity providers, see N.J.A.C. 10:58-2.5, 3.5 and 3.6(h).

(h) Reimbursement shall not be made for, and clients shall not be asked to pay for, broken appointments.

Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).  
See: 30 N.J.R. 1060(a).

Amended by R.1998 d.209, effective May 4, 1998.  
See: 30 N.J.R. 57(a), 30 N.J.R. 1613(a).

Inserted a new (c) and recodified former (c) through (g) as (d) through (h).

### 10:58-1.8 Personal contribution to care requirements for NJ KidCare-Plan C

(a) General policies regarding the collection of personal contribution to care for NJ KidCare-Plan C services are set forth at N.J.A.C. 10:49-9.

(b) Personal contribution to care for NJ KidCare-Plan C services is \$5.00 a visit for office visits, except when the service is provided for prenatal care, preventive care or for family planning services.

1. An office visit is defined as a face-to-face contact with a medical professional which meets the requirements of this chapter and which allows the certified nurse midwife to request reimbursement.

2. Office visits include certified nurse midwife services provided in the office, patient's home, birth center, or any other site, except hospital.

(c) Certified nurse midwives shall not charge a personal contribution to cost of care for services provided to newborns, who are covered under fee-for-service for Plan C; for family planning services, or for prenatal care.

New Rule, R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).  
See: 30 N.J.R. 1060(a).

Former N.J.A.C. 10:58-1.8, Recordkeeping; general, recodified to N.J.A.C. 10:58-1.9.

### 10:58-1.9 Recordkeeping; general

(a) The certified nurse midwife shall keep such legible, individual records as are necessary to fully disclose the kind and extent of services provided, and the medical necessity for those services.

(b) Minimum documentation requirements for services performed by the certified nurse midwife shall include a clinical note or a progress note in the clinical record for each visit, which supports the procedure code or codes to be claimed. This information shall be available upon the request of the New Jersey Medicaid program or its agents.

(c) Documentation of services performed by the CNM shall include, at a minimum:

1. The date of service;
2. The name of the patient;
3. The patient complaint, reason for visit;
4. Subjective findings;
5. Objective findings;
6. An assessment;
7. A plan of care, including, but not limited to, any orders for laboratory work, prescriptions for medications;

8. The signature of the practitioner rendering the service; and

9. Other documentation appropriate to the procedure code being billed. See N.J.A.C. 10:58-3, HCPCS Codes.

(d) Written records in substantiation of the use of a given procedure code shall be available for review and/or inspection if requested by the New Jersey Medicaid program.

(e) Additional documentation requirements can be found at N.J.A.C. 10:49-9.4, 9.5 and 9.6.

(f) The CNM's involvement shall be clearly demonstrated in notes reflecting the practitioner's personal involvement with, or participation in, the service rendered.

Recodified from N.J.A.C. 10:58-1.8 by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998). See: 30 N.J.R. 1060(a).

Former N.J.A.C. 10:58-1.9, Recordkeeping; initial visit, recodified to N.J.A.C. 10:58-1.10.

#### 10:58-1.10 Recordkeeping; initial visit

(a) In order to receive reimbursement for an initial visit, the following documentation, at a minimum, shall be on the record, regardless of the setting where the examination was performed:

1. The chief complaint(s);
2. A complete history of the present illness and related systemic review—including recordings of pertinent negative findings;
3. A pertinent past medical history;
4. A pertinent family history;
5. A full physical examination pertaining to, but not limited to, the history of the present illness and including recordings of pertinent negative findings; and
6. The working diagnoses and treatment plan including ancillary services and drugs ordered.

Recodified from N.J.A.C. 10:58-1.9 by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998). See: 30 N.J.R. 1060(a).

Former N.J.A.C. 10:58-1.10, Recordkeeping; routine or follow-up visits, recodified to N.J.A.C. 10:58-1.11.

#### 10:58-1.11 Recordkeeping; routine or follow-up visits

(a) In order to document the record for reimbursement purposes, the progress note for routine office visits or follow-up care visits shall include the following:

1. In an office:
  - i. The purpose of the visit;
  - ii. Pertinent history obtained;
  - iii. Pertinent physical findings, including pertinent negative physical findings based on (a)i and ii above;

- iv. The procedures, if any, with results;
- v. Laboratory, X-ray, EKG, etc., ordered with results; and

vi. The diagnosis(es).

2. In a hospital or nursing facility setting:

- i. An update of symptoms;
- ii. An update of physical symptoms;
- iii. A resume of findings of procedures, if any done;
- iv. Pertinent positive and negative findings of lab, X-ray;
- v. Additional planned studies, if any, and why; and
- vi. Treatment changes, if any.

Recodified from N.J.A.C. 10:58-1.10 by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998). See: 30 N.J.R. 1060(a).

Former N.J.A.C. 10:58-1.11, Recordkeeping; hospital inpatient stay, recodified to N.J.A.C. 10:58-1.12.

#### 10:58-1.12 Recordkeeping; hospital inpatient stay

(a) To qualify as documentation that the service was rendered by the practitioner during a hospital inpatient stay, the medical record shall contain the CNM's notes, indicating that the practitioner personally:

1. Reviewed the patient's medical history with the patient and/or his or her family, depending upon the medical situation;
2. Performed an examination as appropriate;
3. Confirmed or revised the diagnosis; and
4. Visited and examined the patient on the days for which a claim for reimbursement is made.

Recodified from N.J.A.C. 10:58-1.11 by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998). See: 30 N.J.R. 1060(a).

Former N.J.A.C. 10:58-1.12, Recordkeeping; preventive medicine services; annual health maintenance examination, recodified to N.J.A.C. 10:58-1.13.

#### 10:58-1.13 Recordkeeping; preventive medicine services; annual health maintenance examination

(a) For individuals under 21 years of age, the following shall be performed and documented in the recipient's record:

1. A history (complete initial for new patient, interval for established patient) including past medical history, family history, social history, and systemic review;
2. A developmental and nutritional assessment;
3. A complete, unclothed, physical examination to also include the following:

i. Measurements, including: height and weight; head circumference to 25 months; blood pressure for children age three years or older; and

ii. Vision and hearing screening;

4. An assessment and administration of immunizations appropriate for age and need, as determined by medical practice and professional medical judgment, in accordance with 42 U.S.C. § 1396s and N.J.A.C. 10:58-3;

5. Provisions for further diagnosis, treatment and follow-up, by referral if necessary, of all correctable abnormalities uncovered or suspected;

6. Referral to a dentist for children age three years or older;

7. Laboratory procedures performed or referred if medically necessary. Recommendations are:

i. Hemoglobin/Hematocrit: 10 to 12 years;

ii. Urinalysis: 13 to 18 years;

iii. Tuberculin test (Mantoux) annually;

iv. Lead screening using blood level determinations shall be performed between six and 12 months, at two years of age, and annually up to six years of age. At all other visits, screening shall consist of verbal risk assessment and blood lead level test, as indicated; and

v. Other appropriate screening procedures, if medically necessary, (for example: blood cholesterol, test for ova and parasites, STD);

8. Health education and anticipatory guidance; and

9. An offer of social service assistance; and, if requested, referral to a county welfare agency.

Recodified from N.J.A.C. 10:58-1.12 by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998). See: 30 N.J.R. 1060(a).

Former N.J.A.C. 10:58-1.13, Recordkeeping; home visit or house call, recodified to N.J.A.C. 10:58-1.14.

#### **10:58-1.14 Recordkeeping; home visit or house call**

(a) The record and documentation of a home visit or house call shall become part of the office progress notes and shall include, as appropriate, the following information:

1. The purpose of the visit;

2. The pertinent history obtained;

3. Pertinent physical findings, including pertinent negative physical findings based on (a)1 and 2 above;

4. The procedures, if any performed, with results;

5. Laboratory, X-ray, ECG, etc., ordered with results; and

6. The diagnosis(es) plus treatment plan status relative to present or pre-existing illness(es) plus pertinent recommendations and actions.

Recodified from N.J.A.C. 10:58-1.13 by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998). See: 30 N.J.R. 1060(a).

#### **10:58-1.15 Recordkeeping requirements for birth center services**

(a) Medical records maintained by a birth center for the maternity services shall include, but not be limited to:

1. Patient identification;

2. An initial medical history, results of physical examination, and diagnosis;

3. Progress notes for each visit, which shall include interim history, physical findings, and disposition;

4. Reports of laboratory and other diagnostic studies, and consultation;

5. Any allergies and abnormal drug reactions;

6. A report of the delivery process;

7. The status and condition of the newborn;

8. Documentation of properly executed informed consent of each woman enrolling in a birth center for treatment; and

9. A discharge diagnosis.

New Rule, R.1998 d.209, effective May 4, 1998. See: 30 N.J.R. 57(a), 30 N.J.R. 1613(a).

### **SUBCHAPTER 2. PROVISIONS FOR SPECIFIC SERVICES**

#### **10:58-2.1 Evaluation and management services (HCPCS)**

(a) Evaluation and management services HCPCS procedure codes are used to indicate certain services performed in a CNM's independent practice.

(b) Reimbursement for an initial office visit will be disallowed if a preventive medicine service visit, EPSDT examination visit or office consultation were billed within a 12-month period by the same practitioner, group of practitioners, or shared health care facility sharing a common record.

#### **10:58-2.2 Evaluation and management: initial visits**

(a) For office visits and for other care apart from inpatient hospital, CNMs shall bill for an initial visit only once for a specific patient, subject to the exceptions contained in (b) below. When a shared health care facility, a group of physicians and/or other practitioners (CNMs) share a common record, the Division will reimburse only one initial visit. Further encounters with that patient will be billed and reimbursed by means of "established patient" codes. (See N.J.A.C. 10:58-3.1 through 3.5.)