

CHAPTER 58**NURSE MIDWIFERY SERVICES****Authority**

N.J.S.A. 30:4D-6b(17)(18)(19), 30:4D-12 and 30:4D-7, 7a, b and c.

Source and Effective Date

R.1996 d.99, effective February 20, 1996.
See: 27 N.J.R. 4995(a), 28 N.J.R. 1285(b).

Executive Order No. 66(1978) Expiration Date

Chapter 58, Nurse Midwifery Services, expires on February 20, 2001.

Chapter Historical Note

Chapter 58 was formerly the Independent Clinic Services Manual, and was filed and became effective 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, effective 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 Chapter 58 was repealed by R.1980 d.351, effective August 7, 1980. See: 12 N.J.R. 413(b), 12 N.J.R. 536(d). Chapter 58, Nurse-Midwifery Services, was adopted as new rules by 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, effective February 22, 1991. See: 22 N.J.R. 3613(a), 23 N.J.R. 858(c).

Chapter 58, Nurse-Midwifery Services, was repealed, and a new Chapter 58, Nurse Midwifery Services, was adopted by R.1996 d.99, effective February 20, 1996. See: Source and Effective Date.

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The purpose of this chapter is to provide the standards for the approval of certified nurse midwives as independent providers of services, within their licensed scope of practice and in accordance with the requirements of N.J.A.C. 13:35-2A, to New Jersey Medicaid beneficiaries.

10:58-1.2 Scope

(a) The rules in this chapter govern reimbursement made directly to a nurse midwife provider. Reimbursement shall not be made to a certified nurse midwife unless the nurse midwife has been approved as a Medicaid provider, in accordance with the provisions of this chapter and applicable provisions of N.J.A.C. 10:49.

(b) Reimbursement may be made for services provided by a certified nurse midwife employed by a physician or physician/practitioner group (N.J.A.C. 10:54), by an independent clinic (N.J.A.C. 10:66), or by a hospital (N.J.A.C. 10:52), in accordance with the applicable rules.

10:58-1.3 Definitions

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

“Clinical laboratory services” means professional and technical laboratory services performed by a clinical laboratory certified by HCFA in accordance with the Clinical Laboratory Improvement Act (CLIA) 42 U.S.C. 1396a(9) and ordered by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice as defined by the laws of the State of New Jersey and/or of the state in which the practitioner practices.

“CNM” means certified nurse midwife.

“Early and Periodic Screening, Diagnosis and Treatment (EPSDT)” means a preventive and comprehensive health program for Medicaid recipients under 21 years of age, including the assessment of an individual’s health needs through initial and periodic examinations (screenings), the provision of health education and guidance, and the assurance that any identified health problems are diagnosed and treated at the earliest possible time.

“HealthStart Comprehensive Maternity Care Services Provider” means a certified nurse 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. 10:58-1.5 and 2.16 for requirements.)

“Nurse midwifery services” means services provided by a certified nurse midwife to manage the care of essentially normal women during the maternity cycle; to provide care to essentially normal newborns at the time of delivery; and to provide well-woman health care. Nurse midwifery services are provided within the scope of practice of nurse midwifery and the rules of the Board of Medical Examiners of the State of New Jersey. (See N.J.A.C. 13:35-2A.)

“Prescribed drugs” means simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance, that are:

1. Prescribed by a practitioner licensed or authorized by the State of New Jersey, or the state in which he or she practices, to prescribe drugs and medicine within the scope of his or her license and practice;
2. Dispensed by licensed pharmacists in accordance with regulations promulgated by the New Jersey Board of Pharmacy, N.J.A.C. 13:39; and

3. Dispensed by licensed pharmacists on the basis of a written prescription that is maintained in the pharmacist’s records.

“Well-woman health care” means those preventive and referral services which may include family planning, reproductive health care counseling, and reproductive systems health care screening.

10:58-1.4 Application for provider status; certified nurse midwife

(a) Any nurse midwife may apply to the New Jersey Medicaid program for approval as a Medicaid provider, if he or she:

1. Is a registered professional nurse licensed by the New Jersey State Board of Nursing;
2. Is certified by the American College of Nurse Midwives (ACNM) or the American College of Nurse Midwives Certification Council;
3. Shows evidence of continuing competency, as required by the ACNM; and
4. Is registered as a certified nurse midwife by the New Jersey State Board of Medical Examiners.

(b) See N.J.A.C. 10:49-3 for additional requirements for provider participation.

(c) An applicant shall complete a Medicaid Provider Application (FD-20; see N.J.A.C. 10:49, Appendix, Form #8) and a Medicaid Provider Agreement (FD-62; see N.J.A.C. 10:49, Appendix, Form #9). The forms may be obtained from, and shall be submitted to:

Unisys Corporation
 Provider Enrollment
 P.O. Box 4804
 Trenton, NJ 08650-4804

(d) The application and agreement shall be accompanied by a photocopy of the applicant’s current:

1. License as a registered professional nurse;
2. Registration as a nurse midwife; and
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, CN 364
Trenton, NJ 08625-0364

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

(a) A birth center may enroll as a certified nurse midwife provider in order to receive reimbursement for the certified nurse midwife services provided by a CNM employed by the birth center. In order to receive reimbursement, the birth center must have a current and valid license from the New Jersey Department of Health, in accordance with the provisions of N.J.A.C. 8:43A-28.

(b) 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), and shall submit these to:

Chief, Provider Enrollment
Division of Medical Assistance and Health Services
Mail Code #9
CN 712
Trenton, NJ 08625-0712

(c) 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.

(d) 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.

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 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 program, in accordance with the provisions of this chapter.

(c) A certified nurse midwife who is salaried and whose services are reimbursed as part of the hospital's cost shall not bill fee-for-service to the New Jersey Medicaid 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 program, independent of the hospital charges, if the arrangement with the hospital permits it.

(d) 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.

(e) 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.

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

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

10:58-1.8 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.

10:58-1.9 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.

10:58-1.10 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.

10:58-1.11 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.

10:58-1.12 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.

10:58-1.13 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.

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.)

(b) In the inpatient hospital setting, the initial visit concept still applies for reimbursement purposes, except that subsequent readmissions to the same facility may be designated as initial visits as long as a time interval of 30 days or more has elapsed between admissions.

(c) An initial hospital visit will be disallowed to the same practitioner, group of practitioners, shared health care facility, or practitioners sharing a common record who submit a claim for a consultation and transfer the patient to their service.

(d) In order to use the HCPCS procedure code to bill for an initial visit, the CNM shall provide the minimal documentation in the record regardless of the setting where the examination was performed. See N.J.A.C. 10:58-1.8(c).

10:58-2.3 Evaluation and management: office or other outpatient services (established patient); or subsequent hospital care

Office or other outpatient service, or subsequent hospital care visits shall conform to the CPT-4 description of provider involvement and time. The setting could be office or hospital. The documentation requirements for these visits are found in N.J.A.C. 10:58-1.9.

10:58-2.4 Evaluation and management: preventive medicine

(a) In the absence of patient complaints, the procedure codes identified as preventive medicine services shall be used for adults and for children.

(b) Preventive medicine services codes (new patient) are comparable, in respect to reimbursement level, to an initial visit and, therefore, shall only be billed once per patient. These codes shall be denied when the recipient is seen by the same practitioner, group of practitioners, or involves a shared health care facility sharing a common record. Preventive visits (established patient) for adults shall be considered an annual health maintenance visit.

(c) Requirements for preventive medicine services, the annual health maintenance examination, for new or established patients under the age of 21 are as follows:

1. These codes are not allowable for payment when used following an EPSDT examination performed within the preceding 12 months for a child older than two years of age; and
2. Preventive medicine codes may be used in accordance with the periodicity schedule of preventive visits

recommended by the American Academy of Pediatrics. (See N.J.A.C. 10:58-2.8 through 2.12.)

10:58-2.5 Evaluation and management: consultations requested by CNMs

(a) A consultation shall be reimbursed by the New Jersey Medicaid program when performed by a physician specialist (other than her collaborating physician) recognized as such by the program and when the request is made by or through the patient's CNM. The need for such a request shall be consistent with good medical practice.

(b) When the CNM needs to refer the patient(s) for consultation or for other services, the provider of the consultation or other service shall bill the New Jersey Medicaid program directly and shall be reimbursed directly for the consultation or referred service.

10:58-2.6 Evaluation and management: CNM home services and house calls

(a) The home services recognized as "house calls" refer to a practitioner visit to an individual who would be too ill to go to a practitioner's office and/or is "home bound," as determined by the attending physician, due to his or her physical condition. CNMs shall be reimbursed for house calls.

(b) For purposes of Medicaid reimbursement, "home visits" apply when the provider visits Medicaid recipients who do not qualify as "home bound." CNMs are not reimbursed for home visits.

10:58-2.7 Evaluation and management: emergency department and inpatient hospital services

(a) When a practitioner sees the patient in the emergency room instead of his or her office, the practitioner shall use the same codes for the visit that would have been used if seen in the practitioner's office. Records of that visit shall become part of the notes in the office chart.

(b) When patients are seen by hospital-based emergency room practitioners who are eligible to bill the Medicaid program, the appropriate HCPCS code is used. These "visit" codes are listed at N.J.A.C. 10:58-3.2.

(c) Critical care/prolonged services shall be covered when the patient's situation requires constant practitioner attendance which is given by the practitioner to the exclusion of her other patients and duties, and therefore represents what is beyond the usual service for the practitioner.

1. The critical care/prolonged services code shall not apply to monitoring pregnant women in labor.

2. Critical care/prolonged service shall be documented in the applicable records, as defined by the setting. The records shall show, in the practitioner's handwriting, the time of onset and time of completion of the service. Settings that are applicable are the office, hospital, or home.

3. The reimbursement for the "critical care" or prolonged services utilizes the time parameter, and is all-inclusive, meaning that it shall be the only payment for care provided by the practitioner to the patient at that time. The specific procedures performed during that patient encounter shall not be reimbursed in addition to the "critical care/prolonged services" payment.

10:58-2.8 Early and Periodic Screening, Diagnosis and Treatment (EPSDT); general

(a) The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is a comprehensive health program for Medicaid recipients from birth through 20 years of age. The goal of the program is to assess the recipient's health needs through initial and periodic examinations (screenings); to provide health education and guidance; and to assure that health problems are prevented or diagnosed and treated at the earliest possible time.

(b) For the certification criteria that a physician must meet in providing services to children under 21 years of age, see N.J.A.C. 10:54-1.5, concerning certification of physician services.

(c) As a condition of participation in Medicaid, all ambulatory care facilities (including hospital outpatient departments) providing primary care to children and adolescents from birth through 20 years of age, shall participate in the EPSDT program and shall provide, at a minimum, the required EPSDT screening services.

(d) EPSDT services shall include the following:

1. Screening services;
2. Vision services;
3. Dental services;
4. Hearing services; and
5. Other medically necessary health care, diagnostic services and treatment and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.

(e) EPSDT screening services, vision services, dental services, and hearing services shall be provided at defined intervals as required by the standards contained in N.J.A.C. 10:58-3.

(f) EPSDT screening services shall include the following components: