

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 0364
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
PO Box 0712
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 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) 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.

(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.

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).

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).