25

25 Nurse Midwife

Nurse Midwives manage the care for normal healthy women and their babies in the areas of prenatal; labor and delivery; postpartum care; well-woman gynecology, including family planning services; and normal newborn care.

The practice of Nurse Midwifery must be performed under appropriate physician supervision.

The policy provisions for nurse midwife providers can be found in the *Alabama Medicaid Agency Administrative Code*, Chapter 21.

25.1 Enrollment

HP enrolls nurse midwives and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as a nurse midwife provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for nurse midwifery-related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

Nurse Midwives are assigned a provider type of 09 (Other).The valid specialty for nurse midwives is Nurse Midwife (095).

Enrollment Policy for Nurse Midwives

Providers in this program must possess a license as a Registered Nurse and also a license as a Certified Nurse Midwife.

Nurse midwives must submit the following documents for participation in Medicaid:

- Copy of the current licensure or licensure renewal card
- Copy of the American Midwifery Certification Board (AMCB) certificate
- Copy of the Certified Nurse Midwifery Protocol signed by your collaborating physician
- Letter from the hospital granting admitting privileges for deliveries

If the application is approved, Medicaid offers the applicant a one-year renewable contract.

25.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations. The following policy refers to maternity care billed as fee for service and not as a part of the Maternity Care Program. Refer to Chapter 24, Maternity Care, for more details.

Medicaid bases reimbursement of services on a fee for service for the procedure codes covered for nurse midwife providers.

The services provided by nurse midwives must be within the scope of practice authorized by state law and regulations. Alabama law provides rules under which properly trained nurses can be licensed to practice Nurse Midwifery. Federal law requires that Medicaid include the services of nurse midwives.

A hospital-based nurse midwife who is employed with and paid by a hospital may not bill Medicaid for services performed at the hospital and for which the hospital is reimbursed.

A nurse midwife who is not employed with and paid by a hospital may bill Medicaid using a CMS-1500 claim form.

25.2.1 Covered Services

The maternity services normally provided in maternity cases include antepartum care, delivery, and postpartum care. When a nurse midwife provides total obstetrical care, the claim form should reflect the procedure code for all-inclusive "global" care. The indicated date of service on "global" claims should be the date of delivery.

When a nurse midwife provides eight or more prenatal visits, performs the delivery, and provides postpartum care, the midwife uses a "global" obstetrical code in billing the services. If a nurse midwife submits a "global" code for maternity services, the visits covered by this code are not counted against the recipient's limit of physician office visits per calendar year. For purposes of "global" obstetrical billing, services rendered by members of a group practice are to be considered as services rendered by a single provider.

If a woman is pregnant at the time she becomes eligible for Medicaid benefits, only those services provided during the time that she is eligible are covered.

Antepartum Care

Antepartum care includes all usual prenatal services, such as the initial office visit when the pregnancy is diagnosed, initial and subsequent histories, physical examinations, blood pressure recordings, fetal heart tones, and maternity counseling. Additional claims for routine services should not be filed. Antepartum care also includes routine lab work (such as hemoglobin, hematocrit, and chemical urinalysis). Additional claims for routine lab work should not be filed.

In order to bill for Antepartum Care Only services, nurse midwife providers must use the appropriate procedure codes when billing for the services (i.e., CPT code 59425 for four to six visits or CPT code 59426 for seven or more visits). Antepartum Care Only services filed in this manner do not count against the recipient's annual office visit benefit limits.

Nurse midwives who provide fewer than four visits for antepartum care must use office visit procedure codes when billing for the services. The office visit procedure codes count against the recipient's annual benefit limits for office visits.

Delivery

Delivery includes vaginal delivery (with or without episiotomy) and postpartum care or Vaginal Delivery Only services. The nurse midwife will use the appropriate CPT code when billing delivery services. Do not bill more than one delivery fee for a multiple birth (i.e., twins, triplets). Delivery fees include all professional services related to the hospitalization and delivery services provided by the nurse midwife. Additional claims for the nurse midwife's services in the hospital (e.g., admission) may not be filed.

EXCEPTION: When a nurse midwife's first and only encounter with the recipient occurs at delivery ("walk-in" patient), the midwife may bill for a hospital admission (history and physical) in addition to delivery charges.

Postpartum Care

Postpartum care includes office visits following vaginal delivery for routine postpartum care within 60 days after delivery. Additional claims for routine visits during this time should not be filed. Family planning services performed by the delivering provider on the day of the postpartum exam or within five days of the postpartum exam are noncovered as they are included in the postpartum exam. The only exception to this is Extended Contraceptive Counseling visits, which are performed at the same time as the postpartum exam.

If the provider does not perform the delivery but does provide the postpartum care, family planning services rendered within five days of the postpartum exam are noncovered, as they are included in the postpartum exam.

Family Planning

Family planning services include services that prevent or delay pregnancy. Such services include office visits for evaluation and management of contraceptive issues, including procedures and supplies as appropriate for effective birth control. Nurse midwives are not authorized to perform sterilization procedures. Other surgical procedures such as diaphragm fittings, IUD insertions or removals, and contraceptive implant procedures, are covered when provided according to state laws and regulations.

The nurse midwife may be reimbursed for well-woman gynecological services including the evaluation and management of common medical or gynecological problems such as menstrual problems, Pap smear screenings, menopausal and hormonal treatments, treatment of sexually transmitted diseases, and treatment of minor illnesses (e.g., a minor pelvic inflammatory disease).

25.2.2 Required Written Records

When a patient is accepted for maternity services, the midwife's care must include plans to accomplish the delivery in a licensed hospital. In an emergency, delivery may be accomplished elsewhere. The plans need not be submitted to Medicaid, but the midwife's file should contain written evidence that such plans exist for each patient accepted for global care.

All nurse midwife services must be rendered under appropriate physician supervision. The physician may not bill for these supervisory services.

Midwives' written records should include records naming the supervisory physician(s) and stating the working arrangement. The statement of the working arrangement need not be a formal contract, but it must contain the signature of both parties and must show the date on which it was signed.

Nurse midwives must maintain a complete medical record for each recipient for whom the nurse midwife provides services.

25.2.3 Payment to Physicians

The supervising physician may not bill for supervisory services. The physician may bill Medicaid, however, if it becomes necessary for the physician to perform the delivery or complete a delivery service for the nurse midwife. When the physician bills the delivery-only service, the midwife may bill antepartum care, postpartum care, or both, depending on which service(s) the nurse midwife performed. If the physician bills for delivery only, including postpartum care, the nurse midwife may bill only for the antepartum care provided.

Medicaid covers sterilization at the time of delivery only if the physician performs the procedure, and only if all other Medicaid requirements for sterilization are met. Refer to Chapter 28, Physician, for sterilization requirements.

25.3 Prior Authorization and Referral Requirements

Nurse midwife procedure codes generally do not require prior authorization. Any service warranted outside of these codes must have prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

When filing claims for recipients enrolled in the Patient 1st Program, refer to Chapter 39, Patient 1st, to determine whether your services require a referral from the Primary Medical Provider (PMP).

25.4 Cost Sharing (Copayment)

The copayment does not apply to antepartum care, delivery, and postpartum care and family planning provided by nurse midwives. Copayment is required for well-woman gynecological services except for those recipients under the age of 18.

The provider may not deny services to any eligible Medicaid recipient because of the recipient's inability to pay the cost-sharing (copayment) amount imposed.

25.5 Completing the Claim Form

➢Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

To enhance the effectiveness and efficiency of Medicaid processing, provider should bill Medicaid claims electronically.

Nurse midwives providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required.

This section describes program-specific claims information. Providers should refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

25.5.1 Time Limit for Filing Claims

Medicaid requires all claims for Nurse Midwife providers to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

25.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

Family Planning diagnosis codes are in the V25 category and maternity care diagnosis codes are in the 600 category of the ICD-9-CM.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

25.5.3 Procedure Codes and Modifiers

Nurse midwife providers use the Current Procedural Terminology (CPT) coding system. The CPT manual lists most required procedure codes. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986.

Nurse Midwives are generally reimbursed at 80% of the allowed amount for all services except lab and injectables, which should pay at 100%.

Nurse midwives may submit claims and receive reimbursements for the following services:

Family Planning

Nurse midwives may submit claims and receive reimbursements for Family Planning services, excluding sterilization procedures. See Appendix C, Family Planning, for these procedure codes. The (837) Professional and Institutional electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.

GYN Services

Nurse midwives may bill office procedure codes 99201-99233.

Maternity Care

Code	*Procedure Description*
59400	Routine obstetric care includes antepartum care, vaginal delivery (with or without episiotomy and/or forceps), and postpartum care
59409	Vaginal delivery only
59410	Vaginal delivery only (with or without episiotomy, and/or forceps), including postpartum
59414	Delivery of placenta following delivery of infant outside of hospital
59425*	Antepartum care only (4-6 visits)
59426	Antepartum care only (7 or more visits)
59430	Postpartum care only
54150	Circumcision

NOTE:

* For three or fewer visits, use office visit codes: 99201-99233

25.5.4 Place of Service Codes

The following place of service codes apply when filing claims for nurse midwife services:

POS	*Description*
21	Inpatient Hospital
11	Physician's Office
12	Patient's Home
22	Outpatient
23	ER-Hospital
25	Birthing Center

25.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

25.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N